

MONTANA LEGISLATIVE HISTORY

Chapter 379 19 95

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H. Committee on Business & Labor

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Date Out _____ C

S. Committee on Business & Industry

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Did this bill originate in an interim committee? _____ Yes _____ No

Committee _____

Report _____

1
2 INTRODUCED BY

House BILL NO. 556

3 BY REQUEST OF THE STATE AUDITOR
4

5 A BILL FOR AN ACT ENTITLED: "AN ACT GENERALLY REVISING STATE INSURANCE LAWS; PROVIDING
6 FOR THE DISCLOSURE OF MATERIAL TRANSACTIONS; CREATING A RISK-BASED CAPITAL FOR
7 INSURERS ACT; AMENDING SECTIONS 2-6-109, 33-1-207, 33-1-208, 33-1-209, 33-1-311, 33-1-501,
8 33-2-117, 33-2-301, 33-2-302, 33-2-305, 33-2-307, 33-2-501, 33-2-521, 33-2-523, 33-2-525, 33-2-526,
9 33-2-528, 33-2-529, 33-2-531, 33-2-701, 33-2-705, 33-2-708, 33-2-803, 33-2-806, 33-2-820,
10 33-2-1111, 33-2-1201, 33-2-1216, 33-2-1217, 33-2-1218, 33-2-1510, 33-2-1605, 33-3-431, 33-4-202,
11 33-4-203, 33-5-401, 33-7-117, 33-10-201, 33-10-202, 33-11-102, 33-11-104, 33-11-108, 33-14-304,
12 33-15-301, 33-15-303, 33-16-202, 33-16-235, 33-17-102, 33-17-211, 33-17-405, 33-17-503,
13 33-17-603, 33-17-1001, 33-18-212, 33-18-301, 33-22-131, 33-22-132, 33-22-201, 33-22-202,
14 33-22-301, 33-22-303, 33-22-504, 33-22-508, 33-22-1120, 33-22-1803, 33-22-1819, 33-30-102,
15 33-30-107, 33-30-108, 33-30-202, 33-30-204, 33-30-311, 33-30-1001, AND 33-31-311, MCA; AND
16 REPEALING SECTIONS 33-30-312 AND 33-30-313, MCA."

17
18 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:
19

20 **Section 1.** Section 2-6-109, MCA, is amended to read:

21 **"2-6-109. Prohibition on distribution or sale of mailing lists -- exceptions -- penalty.** (1) Except
22 as provided in subsections (3) through (7), in order to protect the privacy of those who deal with state and
23 local government:

24 (a) ~~no~~ an agency may not distribute or sell for use as a mailing list any list of persons without first
25 securing the permission of those on the list; and

26 (b) ~~no~~ a list of persons prepared by the agency may not be used as a mailing list except by the
27 agency or another agency without first securing the permission of those on the list.

28 (2) As used in this section, "agency" means any board, bureau, commission, department, division,
29 authority, or officer of the state or a local government.

30 (3) Except as provided in 30-9-403, this section does not prevent an individual from compiling a

1 mailing list by examination of original documents or applications which are otherwise open to public
2 inspection.

3 (4) This section does not apply to the lists of registered electors and the new voter lists provided
4 for in 13-2-115 and 13-38-103, to lists of the names of employees governed by Title 39, chapter 31, or
5 to lists of persons holding driver's licenses provided for under 61-5-126.

6 (5) This section ~~shall~~ does not prevent an agency from providing a list to persons providing
7 prelicensing or continuing educational courses subject to Title 20, chapter 30, or specifically exempted
8 ~~therefrom~~ as provided in 20-30-102, or subject to Title 33, chapter 17.

9 (6) This section does not apply to the right of access either by Montana law enforcement agencies
10 or, by purchase or otherwise, of public records dealing with motor vehicle registration.

11 (7) This section does not apply to a corporate information list developed by the secretary of state
12 containing the name, address, registered agent, officers, and directors of business, nonprofit, religious,
13 professional, and close corporations authorized to do business in this state.

14 (8) A person violating the provisions of subsection (1)(b) is guilty of a misdemeanor."
15

16 **Section 2.** Section 33-1-207, MCA, is amended to read:

17 **"33-1-207. Disability insurance.** (1) Disability insurance, including credit disability insurance, is
18 insurance of human beings: (a) against bodily injury, disablement, or death by accident or accidental means
19 or the medical expense thereof or indemnity involved; or

20 (b) against disablement or medical expense or indemnity resulting from sickness and every
21 insurance appertaining thereto.

22 (2) Transaction of disability insurance does not include workers' compensation insurance."
23

24 **Section 3.** Section 33-1-208, MCA, is amended to read:

25 **"33-1-208. Life insurance.** Life insurance, including credit life insurance, is insurance on human
26 lives. The transaction of life insurance includes ~~also~~ the granting of endowment benefits, additional benefits
27 in event of death or dismemberment by accident or accidental means, additional benefits in event of the
28 insured's disability, benefits that provide reimbursement or payment for long-term home health care or
29 long-term care in a nursing home or other related institution, and optional modes of settlement of proceeds
30 of life insurance. Transaction of life insurance does not include workers' compensation insurance."

Section 4. Section 33-1-209, MCA, is amended to read:

"33-1-209. Marine protection and indemnity and wet marine insurance. (1) ~~Marine insurance includes marine protection and indemnity insurance, meaning insurance against, or against legal liability of the insured for, loss, damage, or expense arising out of or incident to the ownership, operation, chartering, maintenance, use, repair, or construction of any vessel, craft, or instrumentality in use in ocean or inland waterways, including liability of the insured for personal injury, illness, or death or for loss of or damage to the property of another person.~~ Marine and transportation insurance means insurance against loss of or damage to:

(a) vessels, craft, aircraft, vehicles, goods, freights, cargoes, merchandise, effects, disbursements, profits, money, securities, choses in action, evidences of debt, valuable papers, bottomry, respondentia, and any interest therein, with respect to risks and perils, including war risks, marine builder's risks, and personal property floater risks, of navigation and transportation or while being assembled, packed, crated, baled, compressed, or similarly prepared for shipment, while awaiting shipment, or during any delays, storage, transshipment, or reshipment;

(b) person or property in connection with marine, transit, or transportation insurance, including liability for loss or damage to either person or property incident to the construction, repair, operation, maintenance, or use of the subject matter of the insurance, but not including life insurance, surety bonds, or insurance against bodily injury arising out of the ownership, maintenance, or use of an automobile;

(c) jewels, jewelry, or precious metals, whether in the course of transportation or otherwise; and

(d) bridges; tunnels; and other instrumentalities of transportation and communication, excluding buildings and their furnishings, fixed contents, and supplies held in storage (unless fire, tornado, sprinkler leakage, hail, explosion, earthquake, riot, or civil commotion are the only hazards to be covered); piers; wharves; docks; slips; and other aids to navigation and transportation, including drydocks, marina railways, and dams and appurtenant facilities for the control of waterways.

(2) Marine protection and indemnity insurance means insurance against liability of the insured for loss, damage, or expense incident to ownership, operation, charter, maintenance, use, repair, or construction of any vessel, craft, or instrumentality for use in ocean or inland waterways. The term includes insurance against the liability of the insured for personal injury, illness, death, or loss or damage of the property of another person.

~~(2)~~(3) For the purposes of this code, wet marine and transportation insurance is that part of marine

1 insurance ~~which that~~ includes only:

2 (a) insurance upon vessels, crafts, and hulls and of interests ~~therein or with relation thereto~~ in or
3 relating to the vessels, crafts, and hulls;

4 (b) insurance of marine builders' risks, marine war risks, and contracts of marine protection and
5 indemnity insurance;

6 (c) insurance of freights and disbursements pertaining to a subject of insurance ~~coming within~~
7 subject to this subsection; and

8 (d) insurance of personal property and interests ~~therein~~ in the personal property, in the course of
9 exportation from or importation into any country and in the course of transportation coastwise or on inland
10 waters, including transportation by land, water, or air from point of origin to final destination, ~~in~~ with
11 respect to, ~~appertaining to, or in connection with any and all~~ risks or perils of navigation, transit, or
12 transportation or while being prepared for ~~and or~~ while awaiting shipment ~~and or~~ or during any delays, storage,
13 transshipment, or reshipment incident ~~thereto~~ to preparation or shipment."

14

15 **Section 5.** Section 33-1-311, MCA, is amended to read:

16 **"33-1-311. General powers and duties.** (1) The commissioner shall enforce the applicable
17 provisions of ~~this code~~ the laws of this state and shall execute the duties imposed on the commissioner by
18 ~~this code~~ the laws of this state.

19 (2) The commissioner ~~shall have~~ has the powers and authority expressly conferred upon the
20 commissioner by or reasonably implied from the provisions of ~~this code~~ the laws of this state.

21 (3) The commissioner shall administer the department to ensure that the interests of insurance
22 consumers are protected.

23 (4) The commissioner may conduct examinations and investigations of insurance matters, in
24 addition to examinations and investigations expressly authorized, as the commissioner considers proper,
25 to determine whether any person has violated any provision of ~~this code~~ the laws of this state or to secure
26 information useful in the lawful administration of any provision. The cost of additional examinations and
27 investigations must be borne by the state.

28 ~~(5) The commissioner has additional powers and duties as provided by other laws of this state.~~

29 ~~(6)~~ (5) The department is a criminal justice agency as defined in 44-5-103."
30

1 **Section 6.** Section 33-1-501, MCA, is amended to read:

2 **"33-1-501. Filing and approval of forms.** (1) (a) An insurance policy or annuity contract form,
3 certificate, enrollment form, application form, printed rider or endorsement form, or form of renewal
4 certificate may not be delivered or issued for delivery in Montana unless the form has been filed with and
5 approved by the commissioner and, if required, the regulatory official of the state of domicile of the insurer,
6 ~~if required~~. This provision does not apply to surety bonds or policies, riders, endorsements, or forms of
7 unique character designed for and used with relation to insurance upon a particular subject or that relate
8 to the manner of distribution of benefits or to the reservation of rights and benefits under life or disability
9 insurance policies and are used at the request of the individual policyholder, contract holder, or certificate
10 holder. Forms for use in property, marine, ~~other than ocean marine and foreign trade coverages~~, casualty,
11 and surety insurance coverages may be filed by a rating organization on behalf of its members and
12 subscribers or by a member or subscriber on its own behalf.

13 (b) The approval of an insurance policy or annuity contract form, certificate, enrollment form,
14 application form, or other related insurance form by the state of domicile may be waived by the
15 commissioner if the commissioner considers the requirements of subsection (1)(a) unnecessary for the
16 protection of Montana insurance consumers. If the requirement is waived, an insurer shall notify the
17 commissioner in writing within 10 days of disapproval, denial, or withdrawal of approval of a form by the
18 state of domicile.

19 (2) The filing must be made not less than 60 days in advance of delivery. Approval of a form by
20 the commissioner constitutes a waiver of any unexpired portion of the waiting period. The commissioner
21 may extend by not more than an additional 60 days the period within which the commissioner may approve
22 or disapprove a form by giving notice of the extension before expiration of the initial 60-day period. The
23 commissioner may at any time, after notice and for cause shown, withdraw any approval.

24 (3) ~~An order of~~ Notice by the commissioner disapproving a form or withdrawing a previous approval
25 must state the grounds for disapproval or withdrawal in sufficient detail to inform the insurer.

26 (4) The commissioner may exempt from the requirements of this section, for so long as the
27 commissioner considers proper, an insurance document, form, or type of document or form ~~specified~~ to
28 which, in the commissioner's opinion, this section may not practicably be applied or the filing and approval
29 of which are, ~~in the commissioner's opinion~~, not desirable or necessary for the protection of the public.

30 (5) This section applies to a form used by a domestic insurer for delivery in a jurisdiction outside

1 Montana if the insurance supervisory official of the jurisdiction informs the commissioner that the form is
2 not subject to approval or disapproval by the official and upon the commissioner's order requiring the form
3 to be submitted to the commissioner for the purpose. The same standards apply to these forms as apply
4 to forms for domestic use.

5 (6) This section and 33-1-502 do not apply to:

6 (a) reinsurance;

7 (b) policies or contracts not issued for delivery in Montana or delivered in Montana, except as
8 provided in subsection (5);

9 (c) ocean marine and foreign trade insurances.

10 (7) Except as provided in chapter 21, group certificates that are delivered or issued for delivery in
11 Montana for group insurance policies effectuated and delivered outside Montana but covering persons
12 resident in Montana must be filed with the commissioner upon request. The certificates must meet the
13 minimum provisions mandated by Montana if Montana law prevails over conflicting provisions of other state
14 law."

15
16 **Section 7.** Section 33-2-117, MCA, is amended to read:

17 **"33-2-117. Continuance, expiration, reinstatement, and amendment of certificate of authority. (1)**

18 Certificates of authority issued or renewed under this code ~~shall~~ must continue in force as long as the
19 insurer is entitled thereto under this code and until suspended or revoked or otherwise terminated; ~~subject,~~
20 ~~however,~~ A certificate is subject to continuance of the certificate by the insurer each year by payment prior
21 to ~~May 15~~ March 1 of the continuation fee provided in 33-2-708.

22 (2) If not ~~so~~ continued by the insurer, ~~its~~ the certificate of authority ~~shall expire~~ expires at midnight
23 on May 31 ~~next~~ following ~~such~~ failure of the insurer ~~so~~ to continue it in force. The commissioner shall
24 promptly notify the insurer of ~~the occurrence of any such failure resulting in impending~~ its failure to pay
25 the continuation fee that can result in the expiration of its certificate of authority.

26 (3) The commissioner may, ~~in his discretion,~~ reinstate a certificate of authority ~~which~~ that the
27 insurer has inadvertently permitted to expire, after the insurer ~~has fully cured all its~~ cures any failures ~~which~~
28 ~~resulted~~ resulting in ~~such~~ expiration and upon payment ~~by the insurer~~ of the fee for reinstatement in
29 addition to the current continuation fee, as provided in 33-2-708. Otherwise, the insurer ~~shall~~ may be
30 granted another certificate of authority only after filing an application ~~therefor~~ and meeting all other

1 requirements ~~as~~ for an original certificate of authority in this state.

2 (4) The commissioner may amend a certificate of authority at any time to accord with changes in
3 the insurer's charter of insuring powers."

4
5 **Section 8.** Section 33-2-301, MCA, is amended to read:

6 **"33-2-301. Short title -- purpose -- definitions.** (1) This part constitutes and may be referred to as
7 "The Surplus Lines Insurance Law".

8 (2) This part must be applied to:

- 9 (a) protect persons seeking insurance in this state;
10 (b) permit surplus lines insurance to be placed with reputable and financially sound unauthorized
11 insurers and to be exported from this state pursuant to this part;

12 (c) establish a system of regulation that will permit orderly access to surplus lines insurance in this
13 state and encourage authorized insurers to provide new and innovative types of insurance to consumers
14 in this state; and

15 (d) protect revenues of this state.

16 (3) As used in this part, the following definitions apply:

17 (a) "Authorized insurer" means an insurer authorized pursuant to 33-2-101 to transact insurance
18 in this state.

19 (b) "Eligible surplus lines insurer" means an unauthorized insurer with which a surplus lines
20 insurance producer may place surplus lines insurance under 33-2-307.

21 (c) "Export" means to place surplus lines insurance with an unauthorized insurer.

22 ~~(d) "Kind of insurance" means one of the types of insurance required to be reported in the annual~~
23 ~~statement filed with the commissioner by an authorized insurer.~~

24 ~~(e)~~(d) "Producing insurance producer" means the individual insurance producer dealing directly with
25 the person seeking insurance.

26 ~~(f)~~(e) "Surplus lines insurance" means any insurance ~~on risks resident, located, or to be performed~~
27 ~~in this state~~ permitted to be placed through a surplus lines insurance producer with an unauthorized insurer
28 eligible to accept the insurance. The term does not include the kinds of insurance exempted under
29 33-2-317.

30 ~~(g)~~(f) "Surplus lines insurance producer" means an individual, partnership, or corporation licensed

under 33-2-305 to place surplus lines insurance ~~on risks resident, located, or to be performed in this state~~
with unauthorized insurers eligible to accept ~~such~~ the insurance.

~~(h)~~(g) "Unauthorized insurer" means an insurer not authorized pursuant to 33-2-101 to transact
insurance in this state. The term includes insurance exchanges authorized under the laws of other states."

Section 9. Section 33-2-302, MCA, is amended to read:

"33-2-302. Conditions precedent to sale of surplus lines insurance. ~~Insurance may be procured
through a licensed surplus lines insurance producer from~~ A producing insurance producer may request a
surplus lines insurance producer to place or a surplus lines insurance producer may place a contract of
insurance with an unauthorized insurer if:

(1) the insurer is an eligible surplus lines insurer;

(2) the line of insurance or the full amount of the line of insurance cannot be obtained from
authorized insurers;

(3) the producing insurance producer makes a diligent effort to place the business with a minimum
of three insurers authorized and actually transacting that line of business in this state. If fewer than three
insurers are authorized and actually transacting the line of business in this state, diligent effort must be met
by searching this lesser market.

(4) the insurance is not procured for the purpose of securing:

(a) a lower premium rate than would be accepted by an authorized insurer; or

(b) an advantage in terms of the insurance contract; ~~and~~

(5) in case of renewal, the line has not become available from an authorized insurer; and

~~(5)~~(6) all other requirements of this part are met."

Section 10. Section 33-2-305, MCA, is amended to read:

"33-2-305. Licensing of surplus lines insurance producer -- fee and bond. (1) A person may not
~~procure~~ place a contract of surplus lines insurance with an unauthorized insurer unless the person is
licensed as a property and casualty insurance producer and possesses a current surplus lines insurance
license issued by the commissioner.

(2) The commissioner shall issue a surplus lines insurance license to any qualified holder of a
current property and casualty insurance producer license only if the insurance producer has:

1 (a) remitted to the commissioner the annual fee prescribed by 33-2-708;

2 (b) submitted to the commissioner a completed license application on a form supplied by the
3 commissioner;

4 (c) been licensed as a property and casualty insurance producer continuously for 5 years or more;
5 and

6 (d) filed with the commissioner and, for as long as the license remains in effect, kept in force a
7 bond in favor of the state of Montana in the amount of \$10,000, with authorized corporate sureties
8 approved by the commissioner. The bond must be conditioned that the insurance producer will conduct
9 business under the license in accordance with the provisions of The Surplus Lines Insurance Law and that
10 the insurance producer will promptly remit the taxes provided in 33-2-311. The bond may not be terminated
11 unless the surety gives the surplus lines insurance producer, the producing insurance producer, and the
12 commissioner at least 30 days' prior written notice of termination.

13 (3) The license expires on April 1 after its date of issue. A surplus lines insurance producer shall
14 renew the license on or before March 1 of each year upon payment of the annual renewal fee prescribed
15 in 33-2-708. A surplus lines insurance producer who fails to apply for a renewal of the license on or before
16 March 1 shall pay a fine of \$100 before the commissioner renews the license.

17 (4) A corporation is eligible to be licensed as a surplus lines insurance producer if:

18 (a) the corporate license lists the individuals within the corporation who have satisfied the
19 requirements of this part to become surplus lines insurance producers; and

20 (b) only those individuals listed on the corporate license transact surplus lines insurance.

21 (5) This section may not be construed to require agents, producers, or brokers acting as
22 intermediaries between a surplus lines insurance producer and an unauthorized insurer under this part to
23 hold a valid Montana surplus lines insurance producer's license."

24
25 **Section 11.** Section 33-2-307, MCA, is amended to read:

26 **"33-2-307. Requirements for eligible surplus lines insurers.** (1) A surplus lines insurance producer
27 may not place insurance with an unauthorized insurer unless, at the time of placement, the unauthorized
28 insurer:

29 (a) has established satisfactory evidence of good reputation and financial integrity; and

30 (b) is qualified under one of the following subsections:

1 (i) the insurer maintains capital and surplus or its equivalent under the laws of its state of domicile,
2 which equals the greater of:

3 (A) the minimum capital and surplus requirements of 33-2-109 and 33-2-110; or

4 (B) ~~\$3~~ \$7 million. An insurer possessing less than ~~\$4~~ \$6 million capital and surplus may satisfy the
5 requirements of this subsection upon an affirmative finding of acceptability by the commissioner. The
6 commissioner's finding must be based upon such factors as quality of management, capital, and surplus
7 of a parent company; company underwriting profit and investment income trends; and company record and
8 reputation within the industry. The commissioner may not make an affirmative finding of acceptability
9 when the surplus lines insurer's capital and surplus is less than ~~\$3~~ \$6 million.

10 (ii) in the case of Lloyd's or another similar ~~unincorporated~~ group ~~of~~ including incorporated and
11 unincorporated alien ~~individual~~ insurers, the insurer maintains a trust fund of not less than \$50 million as
12 security to the full amount of capital and surplus for all policyholders and creditors in the United States of
13 each member of the group. The incorporated members of the group may not engage in any business other
14 than underwriting as a member of the group and must be subject to the same level of solvency regulation
15 and control by the groups of domiciliary regulators as are the unincorporated members. The trust must
16 comply with the terms and conditions established in subsection (1)(b)(iv) for alien insurers.

17 (iii) in the case of an insurance exchange created by the laws of individual states, the insurer
18 maintains capital and surplus, or their substantial equivalent, of not less than \$15 million in the aggregate.
19 For an insurance exchange that maintains funds for the protection of each insurance exchange policyholder,
20 each individual syndicate shall maintain minimum capital and surplus, or their substantial equivalent, of not
21 less than \$1.5 million. If the insurance exchange does not maintain funds for the protection of each
22 insurance exchange policyholder, each individual syndicate shall meet the minimum capital and surplus
23 requirements of subsection (1)(b)(i).

24 (iv) in the case of an alien insurer, the insurer maintains in the United States an irrevocable trust
25 fund in either a national bank or a member of the federal reserve system, in an amount not less than \$1.5
26 million, for the protection of all its policyholders in the United States and the trust fund consists of cash,
27 securities, or letters of credit or of investments of substantially the same character and quality as those
28 which are eligible investments for the capital and statutory reserves of insurers authorized to write like kinds
29 of insurance in this state. The trust fund, which must be included in any calculation of capital and surplus
30 or its equivalent, must have an expiration date that may not at any time be less than 5 years. In addition,

1 the alien insurer must appear on the national association of insurance commissioners' Non-Admitted
2 Insurers Quarterly Listing.

3 (c) has provided the commissioner a copy of its current annual statement, certified by the insurer
4 no more than 6 months after the close of the period reported upon, ~~for~~ quarterly if considered necessary
5 by the commissioner}, and which is either:

6 (i) filed with and approved by the regulatory authority in the state of domicile of the unauthorized
7 insurer; or

8 (ii) certified by an accounting or auditing firm licensed in the jurisdiction of the insurer's state of
9 domicile.

10 (2) In the case of an insurance exchange, the statement required by subsection (1)(c) may be an
11 aggregate combined statement of all underwriting syndicates operating during the period reported.

12 (3) In addition to meeting the requirements in subsection (1), an insurer is an eligible surplus lines
13 insurer only if it appears on the most recent list of eligible surplus lines insurers published at least
14 semiannually by the commissioner. This subsection does not require the commissioner to place or maintain
15 the name of any unauthorized insurer on the list of eligible surplus lines insurers. An action may not lie
16 against the commissioner or an employee of the commissioner for anything said in issuing the list of eligible
17 surplus lines insurers referred to in this subsection.

18 (4) (a) The commissioner may declare an eligible surplus lines insurer ineligible if at any time the
19 commissioner has reason to believe that it:

20 (i) is in unsound financial condition;

21 (ii) is no longer eligible under subsections (1) through (3);

22 (iii) has willfully violated the laws of this state; or

23 (iv) does not make reasonably prompt payment of just losses and claims in this state or elsewhere.

24 (b) The commissioner shall promptly mail notice of all declarations to each surplus lines insurance
25 producer.

26 (5) As used in this section, the following definitions apply:

27 (a) "Capital", as used in the financial requirements of this section, means funds invested in for
28 stocks or other evidences of ownership.

29 (b) "Surplus", as used in the financial requirements of this section, means funds over and above
30 liabilities and capital of the insurer for the protection of policyholders."

1 **Section 12.** Section 33-2-501, MCA, is amended to read:

2 **"33-2-501. Assets allowed.** In any determination of the financial condition of an insurer, there
3 must be allowed as assets only assets that are owned by the insurer and that consist of:

4 (1) cash in the possession of the insurer or in transit under its control and including the true
5 balance of any deposit in a solvent bank or trust company;

6 (2) investments, securities, properties, and loans acquired or held in accordance with this code and
7 in connection therewith the following items:

8 (a) interest due or accrued on any bond or evidence of indebtedness which is not in default and
9 which is not valued on a basis including accrued interest;

10 (b) declared and unpaid dividends on stock and shares unless the amount has otherwise been
11 allowed as an asset;

12 (c) interest due or accrued upon a collateral loan in an amount not to exceed 1 year's interest on
13 the loan;

14 (d) interest due or accrued on deposits in solvent banks and trust companies and interest due or
15 accrued on other assets, if the interest is in the judgment of the commissioner a collectible asset;

16 (e) interest due or accrued on a mortgage loan in an amount not exceeding in any event the
17 amount, if any, of the excess of the value of the property less delinquent taxes on the property over the
18 unpaid principal. Interest accrued for a period in excess of 18 months may not be allowed as an asset.

19 (f) rent due or accrued on real property if the rent is not in arrears for more than 3 months and rent
20 more than 3 months in arrears if the payment of the rent is adequately secured by property held in the
21 name of the tenant and conveyed to the insurer as collateral;

22 (g) the unaccrued portion of taxes paid prior to the due date on real property;

23 (3) premium notes, policy loans, and other policy assets and liens on policies and certificates of
24 life insurance and annuity contracts and accrued interest, in an amount not exceeding the legal reserve and
25 other policy liabilities carried on each individual policy;

26 (4) the net amount of uncollected and deferred premiums and annuity considerations in the case
27 of a life insurer;

28 (5) premiums in the course of collection, other than for life insurance, not more than 3 months past
29 due, less commissions payable on the premiums. The limitation in this subsection does not apply to
30 premiums payable directly or indirectly by the United States government or by any of its instrumentalities.

1 (6) installment premiums other than life insurance premiums to the extent of the unearned premium
2 reserve carried on the policy to which premiums apply;

3 (7) notes and like written obligations not past due, taken for premiums other than life insurance
4 premiums, on policies permitted to be issued on that basis, to the extent of the unearned premium reserves
5 carried on the policies;

6 (8) the full amount of reinsurance recoverable by a ceding insurer from a solvent reinsurer and
7 which reinsurance is authorized under chapter 2, part 12;

8 (9) amounts receivable by an assuming insurer representing funds withheld by a solvent ceding
9 insurer under a reinsurance treaty;

10 (10) deposits or equities recoverable from underwriting associations, syndicates, and reinsurance
11 funds or from any suspended banking institution, to the extent considered by the commissioner available
12 for the payment of losses and claims and at values to be determined by the commissioner;

13 (11) electronic data processing equipment if the cost of the equipment is at least \$100,000, which
14 ~~cost must be~~ amortized in full over a period of not to exceed 10 8 calendar years. However, with regard
15 ~~to life insurers, the equipment must be allowed as an asset if the cost of the equipment is at least \$25,000,~~
16 ~~which cost must be amortized in full over a period of not to exceed 5 calendar years, and the amount of~~
17 the asset allowed may not exceed 1% of the total of the other allowable assets of the insurer.

18 (12) all assets, whether or not consistent with the provisions of this section, as may be allowed
19 pursuant to the annual statement form approved by the commissioner for the kinds of insurance to be
20 reported upon in the annual statement;

21 (13) other assets, not inconsistent with the provisions of this section, considered by the
22 commissioner to be available for the payment of losses and claims, at values to be determined by the
23 commissioner."

24
25 **Section 13.** Section 33-2-521, MCA, is amended to read:

26 **"33-2-521. Standard valuation of reserve liabilities law -- life insurance.** (1) The commissioner
27 shall annually value or cause to be valued the reserve liabilities (~~hereinafter called~~ reserves) for all
28 outstanding life insurance policies and annuity and pure endowment contracts of every life insurer doing
29 business in this state and may certify the amount of any ~~such~~ reserves, specifying the mortality table or
30 tables, rate or rates of interest, and methods (net level premium method or other) used in the calculation

1 of such reserves. In calculating such the reserves, he the commissioner may use group methods and
2 approximate averages for fractions of a year or otherwise. ~~In the case of an alien insurer, such valuation~~
3 ~~shall be limited to its insurance transactions in the United States.~~

4 (2) ~~For the purpose of making such valuation, the commissioner may employ a competent actuary~~
5 ~~who shall be paid by the insurer for which the service is rendered; but a domestic insurer may make such~~
6 ~~valuation and it may be received by the commissioner upon satisfactory proof of its correctness.~~ In lieu of
7 the valuation of the reserves ~~herein~~ required in this section of any foreign or alien insurer, the commissioner
8 may accept any valuation made or caused to be made by the insurance supervisory official of any state or
9 other jurisdiction when ~~such the~~ valuation complies with the minimum standard ~~herein~~ provided in this
10 section and if the official of ~~such the other~~ state or jurisdiction accepts as sufficient and valid for all legal
11 purposes the certificate of valuation of the commissioner when ~~such the~~ certificate states the valuation to
12 have been made in a specified manner according to which the aggregate reserves would be at least as large
13 as if they had been computed in the manner prescribed by the law of that state or jurisdiction.

14 (3) Any insurer ~~which at any time shall have~~ that has adopted any standard of valuation producing
15 greater aggregate reserves than those calculated according to the minimum standard ~~herein~~ provided in this
16 section may, with the approval of the commissioner, adopt any lower standard of valuation but not lower
17 than the minimum ~~herein provided in this section.~~ For the purposes of this section, the holding of additional
18 reserves previously determined by a qualified actuary to be necessary to render the opinion required in
19 subsection (4) may not be considered to be the adoption of a higher standard of valuation.

20 (4) (a) Each life insurer doing business in this state shall annually submit the opinion of a qualified
21 actuary as to whether the reserves and related actuarial items held in support of the policies and contracts
22 specified by the commissioner by rule are computed appropriately, are based on assumptions that satisfy
23 contractual provisions, are consistent with prior reported amounts, and comply with applicable laws of this
24 state. The commissioner by rule shall define the specifics of this opinion and add any other items
25 considered necessary to its scope.

26 (b) Each life insurer, except as exempted by or pursuant to regulation, shall also annually include
27 in the opinion required by subsection (4)(a) an opinion of the same qualified actuary as to whether the
28 reserves and related actuarial items held in support of the policies and contracts specified by the
29 commissioner by rule, when considered in light of the assets held by the insurer with respect to the
30 reserves and related actuarial items, including but not limited to the investment earnings on the assets and

1 the considerations anticipated to be received and retained under the policies and contracts, make adequate
2 provision for the insurer's obligations under the policies and contracts, including but not limited to the
3 benefits under and expenses associated with the policies and contracts.

4 (c) The commissioner may provide by rule for a transition period for establishing any higher
5 reserves that the qualified actuary may consider necessary in order to render the opinion required by this
6 subsection (4).

7 (d) Each opinion required by this subsection (4) must be governed by the following provisions:

8 (i) A memorandum, in form and substance acceptable to the commissioner as specified by rule,
9 must be prepared to support each actuarial opinion.

10 (ii) If the insurer fails to provide a supporting memorandum at the request of the commissioner
11 within a period specified by rule or if the commissioner determines that the supporting memorandum
12 provided by the insurer fails to meet the standards prescribed by the rules or is otherwise unacceptable to
13 the commissioner, the commissioner may engage a qualified actuary at the expense of the insurer to review
14 the opinion and the basis for the opinion and to prepare any supporting memorandum as is required by the
15 commissioner.

16 (iii) The opinion must be submitted with the annual statement reflecting the valuation of the reserve
17 liabilities for each year ending on or after December 31, 1995.

18 (iv) The opinion must apply to all business in force, including individual and group health insurance
19 plans, in form and substance acceptable to the commissioner as specified by rule.

20 (v) The opinion must be based on standards adopted from time to time by the actuarial standards
21 board and on additional standards as the commissioner may prescribe by rule.

22 (vi) In the case of an opinion required to be submitted by a foreign or alien insurer, the
23 commissioner may accept the opinion filed by that insurer with the insurance supervisory official of another
24 state if the commissioner determines that the opinion reasonably meets the requirements applicable to a
25 company domiciled in this state.

26 (vii) Except in cases of fraud or willful misconduct, the qualified actuary is not liable for damages
27 to any person, other than the insurer and the commissioner, for any act, error, omission, decision, or
28 conduct with respect to the actuary's opinion.

29 (viii) Disciplinary action by the commissioner against the insurer or the qualified actuary must be
30 defined in rules by the commissioner.

1 (ix) Any memorandum in support of the opinion and any other material provided by the insurer to
2 the commissioner in connection with those items must be kept confidential by the commissioner, may not
3 be made public, and is subject to subpoena, other than for the purpose of defending an action seeking
4 damages from any person by reason of any action required by this subsection (4) or by rules promulgated
5 under this subsection (4). However, the memorandum or other material may otherwise be released by the
6 commissioner:

7 (A) with the written consent of the insurer; or

8 (B) to the American academy of actuaries upon request stating that the memorandum or other
9 material is required for the purpose of professional disciplinary proceedings and setting forth procedures
10 satisfactory to the commissioner for preserving the confidentiality of the memorandum or other material.
11 Once any portion of the confidential memorandum is cited by the insurer in its marketing, is cited before
12 any governmental agency other than a state insurance department, or is released by the insurer to the news
13 media, all portions of the confidential memorandum are no longer confidential.

14 (5) For purposes of this section, "qualified actuary" means a member in good standing of the
15 American academy of actuaries who meets the requirements set forth in the academy's rules."

16
17 **Section 14.** Section 33-2-523, MCA, is amended to read:

18 **"33-2-523. Contracts on or after the operative date of 33-20-213 -- valuation.** (1) This section
19 ~~shall apply~~ applies to only those policies and contracts issued on or after the operative date of 33-20-213,
20 except as otherwise provided in 33-2-524 for group annuity and pure endowment contracts issued prior
21 to that date.

22 (2) Except as otherwise provided in 33-2-524, ~~and~~ 33-2-525, and [section 76(2)], the minimum
23 standard for the valuation of all ~~such~~ the policies and contracts issued prior to October 1, 1995, shall must
24 be the standard provided by the laws in effect prior to October 1, 1995. Except as otherwise provided in
25 33-2-524, 33-2-525, and [section 76(2)], the minimum standard for the valuation of all policies and
26 contracts must be the commissioner's reserve valuation methods defined in 33-2-525, ~~and~~ 32-2-526(3),
27 and (4), and [section 76], 5% interest for group annuity and pure endowment contracts, and 3 1/2%
28 interest for all other ~~such~~ policies and contracts or, in the case of life insurance policies and contracts other
29 than annuity and pure endowment contracts issued on or after March 17, 1973, 4% interest for ~~such~~ all
30 other policies issued prior to July 1, 1979, 5 1/2% interest for single-premium life insurance policies, and

4 1 1/2% interest for ~~such~~ policies issued on or after July 1, 1979, and the following tables:

(a) for all ordinary policies of life insurance issued on the standard basis, excluding any disability and accidental death benefits in ~~such~~ the policies;

(i) the commissioner's 1941 standard ordinary mortality table;

(ii) for ~~such~~ policies issued prior to the operative date of 33-20-206, as amended, and the commissioner's 1958 standard ordinary mortality table for ~~such~~ policies issued on or after that operative date but prior to January 1, 1989, except that for any category of ~~such~~ the policies issued on female risks, modified net premiums and present values, referred to in 33-2-525 and 33-2-526, may be calculated, at the option of the insurer, with the approval of the commissioner, according to an age younger than the actual age of the insured; or

(ii) for ~~such~~ policies issued on or after January 1, 1989:

(A) the commissioner's 1980 standard ordinary mortality table;

(B) at the election of the company for any one or more specified plans of life insurance, the commissioner's 1980 standard ordinary mortality table with 10-year select mortality factors; or

(C) any ordinary mortality table adopted after 1980 by the national association of insurance commissioners that is approved by the commissioner by rule for use in determining the minimum standard of valuation for ~~such~~ policies;

(b) for all industrial life insurance policies issued on the standard basis, excluding any disability and accidental death benefits in ~~such~~ the policies, the 1941 standard industrial mortality table for ~~such~~ policies issued prior to the operative date of 33-20-207, ~~as amended~~, and, for ~~such~~ policies issued on or after that operative date, the commissioner's 1961 standard industrial mortality table or any industrial mortality table adopted after 1980 by the national association of insurance commissioners that is approved by the commissioner by rule for use in determining the minimum standard of valuation for ~~such~~ the policies;

(c) for individual annuity and pure endowment contracts, excluding any disability and accidental death benefits in ~~such~~ the policies, the 1937 standard annuity mortality table or, at the option of the insurer, the annuity mortality table for 1949, ultimate, or any modification of either of these tables approved by the commissioner;

(d) for group annuity and pure endowment contracts, excluding any disability and accidental death benefits in ~~such~~ the policies, the group annuity mortality table for 1951, any modification of ~~such~~ the table approved by the commissioner, or, at the option of the insurer, any of the tables or modifications of tables

1 specified for individual annuity and pure endowment contracts;

2 (e) (i) for total and permanent disability benefits in or supplementary to ordinary policies or
3 contracts:

4 (A) for policies or contracts issued on or after January 1, 1966, the tables of period 2 disablement
5 rates and the 1930 to 1950 termination rates of the 1952 disability study of the society of actuaries, with
6 due regard to the type of benefit, or any tables of disablement rates and termination rates adopted after
7 1980 by the national association of insurance commissioners that are approved by the commissioner by
8 rule for use in determining the minimum standard of valuation for ~~such~~ the policies;

9 (B) for policies or contracts issued on or after January 1, 1961, and prior to January 1, 1966,
10 either ~~such~~ the tables or, at the option of the insurer, the class 3 disability table (1926); and

11 (C) for policies issued prior to January 1, 1961, the class 3 disability table (1926);

12 (ii) any ~~such~~ table ~~shall~~ must, for active lives, be combined with a mortality table permitted for
13 calculating the reserves for life insurance policies;

14 (f) (i) for accidental death benefits in or supplementary to policies:

15 (A) for policies issued on or after January 1, 1966, the 1959 accidental death benefits table or any
16 accidental death benefits table adopted after 1980 by the national association of insurance commissioners
17 that is approved by the commissioner by rule for use in determining the minimum standard of valuation for
18 ~~such~~ the policies;

19 (B) for policies issued on or after January 1, 1961, and prior to January 1, 1966, either such table
20 or, at the option of the insurer, the intercompany double indemnity mortality table; and

21 (C) for policies issued prior to January 1, 1961, the intercompany double indemnity mortality table;

22 (ii) either table ~~shall~~ must be combined with a mortality table permitted for calculating the reserves
23 for life insurance policies;

24 (g) for group life insurance, life insurance issued on the substandard basis, and other special
25 benefits, ~~such~~ the tables as may be approved by the commissioner."

26
27 **Section 15.** Section 33-2-525, MCA, is amended to read:

28 **"33-2-525. Commissioner's reserve valuation method.** (1) Except as otherwise provided in
29 subsection (4) of this section, and 33-2-526(3) and (4), and [section 76(2)], reserves according to the
30 commissioner's reserve valuation method, for the life insurance and endowment benefits of policies

1 providing for a uniform amount of insurance and requiring the payment of uniform premiums, ~~shall~~ must
2 be the excess, if any, of the present value, at the date of valuation, of ~~such~~ future guaranteed benefits
3 provided for by ~~such~~ the policies, over the then present value of any future modified net premiums ~~therefor~~.
4 The modified net premiums for any ~~such~~ policy ~~shall~~ must be ~~such~~ the uniform percentage of the respective
5 contract premiums for ~~such~~ the benefits that the present value, at the date of issue of the policy, of all ~~such~~
6 modified net premiums ~~shall~~ must be equal to the sum of the then present value of ~~such~~ the benefits
7 provided for by the policy and the excess of (a) over (b), as follows:

8 (a) a net level annual premium equal to the present value, at the date of issue, of ~~such~~ benefits
9 provided for after the first policy year, divided by the present value, at the date of issue of an annuity of
10 one per annum payable on the first and each subsequent anniversary of ~~such~~ the policy on which a
11 premium falls due; ~~provided, however~~ However, that ~~such~~ the net level annual premium ~~shall~~ may not
12 exceed the net level annual premium on the 19-year premium whole life plan for insurance of the same
13 amount at an age 1 year higher than the age at issue of ~~such~~ the policy;

14 (b) a net 1-year term premium for ~~such~~ benefits provided for in the first policy year.

15 (2) (a) For ~~every~~ each life insurance policy issued on or after January 1, 1987, for which the
16 contract premium in the first policy year exceeds that of the second year, for which ~~no~~ a comparable
17 additional benefit is not provided in the first year for ~~such~~ the excess, and that provides an endowment
18 benefit, a cash surrender value, or a combination of both in an amount greater than ~~such~~ the excess
19 premium, the reserve according to the commissioner's reserve valuation method, as of any policy
20 anniversary occurring on or before the assumed ending date as the first policy anniversary on which the
21 sum of any endowment benefit and any cash surrender value then available is greater than ~~such~~ the excess
22 premium, is, except as otherwise provided in 33-2-526, the greater of the reserve as of ~~such~~ the policy
23 anniversary calculated as described in subsection (1) or the reserve as of ~~such~~ the policy anniversary
24 calculated as described in subsection (1) with the following exceptions:

25 (i) the value defined in subsection (1)(a) is reduced by 15% of the amount of ~~such~~ the excess
26 first-year premium;

27 (ii) all present values of benefits and premiums are determined without reference to premiums or
28 benefits provided for in the policy after the assumed ending date;

29 (iii) the policy is assumed to mature on ~~such~~ the assumed ending date as an endowment; and

30 (iv) the cash surrender value provided on ~~such~~ the assumed ending date is considered an

1 endowment benefit.

2 (b) In making the comparisons in subsection (2)(a), the mortality and interest bases stated in
3 33-2-523 and 33-2-527 must be used.

4 (3) Reserves according to the commissioner's reserve valuation method for the following ~~shall~~ must
5 be calculated by a method consistent with the principles of this section, except that any extra premiums
6 charged because of impairments or special hazards ~~shall~~ must be disregarded in the determination of
7 modified net premiums:

8 (a) life insurance policies providing for a varying amount of insurance or requiring the payment of
9 varying premiums;

10 (b) group annuity and pure endowment contracts purchased under a retirement plan or plan of
11 deferred compensation, established or maintained by an employer, ~~(including a partnership or sole~~
12 ~~proprietorship),~~ or by an employee organization, or by both, other than a plan providing individual retirement
13 accounts or individual retirement annuities under section 408 of the Internal Revenue Code, as ~~now or~~
14 ~~hereafter~~ amended;

15 (c) disability and accidental death benefits in all policies and contracts; and

16 (d) all other benefits, except life insurance and endowment benefits in life insurance policies and
17 benefits provided by all other annuity and pure endowment contracts.

18 (4) (a) Subsection (4)(b) applies to any annuity and pure endowment contracts other than group
19 annuity and pure endowment contracts purchased under a retirement plan or plan of deferred compensation
20 established or maintained by an employer, ~~(including a partnership or sole proprietorship),~~ or by an
21 employee organization, or by both, other than a plan providing individual retirement accounts or individual
22 retirement annuities under section 408 of the Internal Revenue Code, as ~~now or hereafter~~ amended.

23 (b) Reserves according to the commissioner's annuity reserve method for benefits under annuity
24 or pure endowment contracts, excluding any disability and accidental death benefits in ~~such the~~ the contracts,
25 ~~shall~~ must be the greatest of the respective excesses of the present values, at the date of valuation, of the
26 future guaranteed benefits, including guaranteed nonforfeiture benefits, provided for by ~~such the~~ the contracts
27 at the end of each respective contract year, over the present value, at the date of valuation, of any future
28 valuation considerations derived from future gross considerations required by the terms of ~~such the~~ the contract
29 that become payable prior to the end of ~~such the~~ the respective contract year. The future guaranteed benefits
30 ~~shall~~ must be determined by using the mortality table, if any, and the interest rate or rates specified in ~~such~~

1 the contracts for determining guaranteed benefits. The valuation considerations are the portions of the
2 respective gross considerations applied under the terms of ~~such~~ the contracts to determine nonforfeiture
3 values."

4
5 **Section 16.** Section 33-2-526, MCA, is amended to read:

6 **"33-2-526. Limits -- options -- minimum reserves.** (1) ~~In no event shall an~~ An insurer's aggregate
7 reserves for all life insurance policies, excluding disability and accidental death benefits issued on or after
8 October 1, 1995, may not be less than the aggregate reserves calculated in accordance with the methods
9 set forth in 33-2-525, ~~and~~ subsection (3) of this section, [section 76(2)] and the mortality table or tables
10 and rate or rates of interest used in calculating nonforfeiture benefits for ~~such~~ the policies.

11 (2) Reserves for all policies and contracts issued prior to October 1, 1995, may be calculated, at
12 the option of the insurer, according to standards that produce greater aggregate reserves for those policies
13 and contracts than the minimum reserves required by the laws in effect immediately prior to October 1,
14 1995. Reserves for any category of policies, contracts, or benefits as established by the commissioner,
15 issued on or after October 1, 1995, may be calculated at the option of the insurer according to any
16 standards which produce greater aggregate reserves for ~~such~~ a category than those calculated according
17 to the minimum standard ~~herein~~ provided in this section, but the rate or rates of interest used for policies
18 and contracts, other than annuity and pure endowment contracts, ~~shall~~ may not be higher than the
19 corresponding rate or rates of interest used in calculating any nonforfeiture benefits provided for ~~therein~~
20 a category.

21 (3) If in any contract year the gross premium charged by any life insurer on any policy or contract
22 is less than the valuation net premium for the policy or contract calculated by the method used in
23 calculating the reserve ~~thereon~~ on the policy or contract but using the minimum valuation standards of
24 mortality and rate of interest, the minimum reserve required for ~~such~~ the policy or contract ~~shall~~ must be
25 the greater of either the reserve calculated according to the mortality table, rate of interest, and method
26 actually used for ~~such~~ the policy or contract or the reserve calculated by the method actually used for ~~such~~
27 the policy or contract but using the minimum standards of mortality and rate of interest and replacing the
28 valuation net premium by the actual gross premium in each contract year for which the valuation net
29 premium exceeds the actual gross premium. The minimum valuation standards of mortality and rate of
30 interest referred to in this section are those standards stated in 33-2-524 and 33-2-527.

(4) For every life insurance policy issued after December 30, 1986, for which the gross premium in the first policy year exceeds that of the second year, for which ~~no~~ a comparable additional benefit is not provided in the first year for ~~such an~~ excess, and that provides an endowment benefit, a cash surrender value, or a combination of both in an amount greater than ~~such the~~ excess premium, subsections (1) through (3) of this section must be applied as if the method actually used in calculating the reserve for ~~such the~~ policy were the method described in 33-2-525(1). The minimum reserve at each policy anniversary of ~~such a the~~ policy must be the greater of the minimum reserve calculated in accordance with 33-2-525 and the minimum reserve calculated in accordance with this section."

Section 17. Section 33-2-528, MCA, is amended to read:

"33-2-528. Interest rate weighting factor. (1) The weighting factors referred to in the formulas stated in 33-2-527 are as follows:

(a) (i) for life insurance:

Guarantee Duration in Years	Weighting Factors
10 or less	.50
More than 10 but not more than 20	.45
More than 20	.35

(ii) for life insurance, the guarantee duration is the maximum number of years the life insurance can remain in force on a basis guaranteed in the policy or under options to convert to plans of life insurance with premium rates or nonforfeiture values, or both, that are guaranteed in the original policy;

(b) .80 for single premium immediate annuities and for annuity benefits involving life contingencies arising from other annuities with cash settlement options and guaranteed interest contracts with cash settlement options;

(c) for other annuities and for guaranteed interest contracts, except as stated in subsection (1)(b), according to the guarantee duration established in ~~subsection (2)~~ subsections (1)(c)(i) through (1)(c)(iii) and the type of plan rules and definitions established in established in subsection subsections (2), (3), and (4):

(i) for annuities and guaranteed interest contracts valued on an issue year basis:

Guarantee Duration in Years	Weighting Factor for Plan Type
-----------------------------	-----------------------------------

	A	B	C
5 or less	.80	.60	.50
More than 5 but not more than 10	.75	.60	.50
More than 10 but not more than 20	.65	.50	.45
More than 20	.45	.35	.35

Plan Type

(ii)	A	B	C
------	---	---	---

for annuities and guaranteed interest contracts valued on a change-in-fund basis, the factors shown in subsection (1)(c)(i) increased by:

.15	.25	.05
-----	-----	-----

Plan Type

(iii)	A	B	C
-------	---	---	---

for annuities and guaranteed interest contracts valued on an issue year basis, ~~other than those with no~~ without cash settlement options, that do not guarantee interest on considerations received more than 1 year after issue or purchase and for annuities and guaranteed interest contracts valued on a change-in-fund basis that do not guarantee interest rates on considerations received more than 12 months beyond the valuation date, the factors set forth in subsection (1)(c)(i) or derived in subsection (1)(c)(ii) increased by:

.05	.05	.05
-----	-----	-----

(2) For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, the guarantee duration is the number of years for which the contract guarantees interest rates in excess of the calendar year statutory valuation interest rate for life insurance policies with guarantee duration in excess of 20 years. For other annuities ~~with no~~ without cash settlement options and for guaranteed interest contracts ~~with no~~ without cash settlement options, the guarantee duration is the number of years from the date of issue or date of purchase to the date annuity benefits are scheduled to commence.

(3) Plan types used in subsection (1)(c) are:

(a) Plan Type A--No withdrawal is permitted or at any time policyholder may withdraw funds only:

1 (i) with an adjustment to reflect changes in interest rates or asset values since receipt of the funds
2 by the insurance company;

3 (ii) without ~~such an~~ adjustment but in installments over 5 years or more; or

4 (iii) as an immediate life annuity.

5 (b) Plan Type B--(i) Before expiration of the interest rate guarantee, no withdrawal is permitted or
6 a policyholder may withdraw funds only:

7 (A) with an adjustment to reflect changes in interest rates or asset values since receipt of the funds
8 by the insurance company;

9 (B) without ~~such an~~ adjustment but in installments over 5 years or more.

10 (ii) At the end of the interest rate guarantee, funds may be withdrawn without ~~such an~~ adjustment
11 in a single sum or installments over less than 5 years.

12 (c) Plan Type C--A policyholder may withdraw funds before expiration of the interest rate guarantee
13 in a single sum or installments over less than 5 years either:

14 (i) without adjustment to reflect changes in interest rates or asset values since receipt of the funds
15 by the insurance company; or

16 (ii) subject only to a fixed surrender charge stipulated in the contract as a percentage of the fund.

17 (4) (a) An insurer may elect to value guaranteed interest contracts with cash settlement options
18 and annuities with cash settlement options on either an issue year basis or on a change-in-fund basis.
19 Guaranteed interest contracts ~~with no~~ without cash settlement options and other annuities ~~with no~~ without
20 cash settlement options must be valued on an issue year basis.

21 (b) As used in subsection (4):

22 (i) issue year basis of valuation is a valuation basis under which the interest rate used to determine
23 the minimum valuation standard for the entire duration of the annuity or guaranteed interest contract is the
24 calendar year valuation interest rate for the year of issue or year of purchase of the annuity or guaranteed
25 interest contract; and

26 (ii) change-in-fund basis of valuation is a valuation basis under which the interest rate used to
27 determine the minimum valuation standard applicable to each change in the fund held under the annuity
28 or guaranteed interest contract is the calendar year valuation interest rate for the year of the change in the
29 fund."

30

1 **Section 18.** Section 33-2-529, MCA, is amended to read:

2 **"33-2-529. Reference interest rate.** (1) The reference interest rate referred to in the formulas in
3 33-2-527 is:

4 (a) for all life insurance, the lesser of the average over a period of 36 months and the average over
5 a period of 12 months, ending on June 30 of the calendar year next preceding the year of issue, of
6 Moody's ~~corporate bond yield average~~—monthly average ~~corporate~~ composite yield on seasoned corporate
7 bonds;

8 (b) for single-premium immediate annuities and for annuity benefits involving life contingencies
9 arising from other annuities with cash settlement options and guaranteed interest contracts with cash
10 settlement options, the average over a period of 12 months, ending on June 30 of the calendar year of
11 issue or purchase, of Moody's ~~corporate bond yield average~~—monthly average ~~corporate~~ composite yield
12 on seasoned corporate bonds;

13 (c) for other annuities with cash settlement options and guaranteed interest contracts with cash
14 settlement options valued on a year-of-issue basis, except as stated in subsection (1)(b), with guarantee
15 duration in excess of 10 years, the lesser of the average over a period of 36 months and the average over
16 a period of 12 months, ending on June 30 of the calendar year of issue or purchase, of Moody's ~~corporate~~
17 ~~bond yield average~~—monthly average ~~corporate~~ composite yield on seasoned corporate bonds;

18 (d) for other annuities with cash settlement options and guaranteed interest contracts with cash
19 settlement options valued on a year-of-issue basis, except as stated in subsection (1)(b), with guarantee
20 duration of 10 years or less, the average over a period of 12 months, ending on June 30 of the calendar
21 year of issue or purchase, of Moody's ~~corporate bond yield average~~—monthly average ~~corporate~~
22 composite yield on seasoned corporate bonds;

23 (e) for other annuities ~~with no~~ without cash settlement options and for guaranteed interest
24 contracts ~~with no~~ without cash settlement options, the average over a period of 12 months, ending on June
25 30 of the calendar year of issue or purchase, of Moody's ~~corporate bond yield average~~—monthly average
26 ~~corporate~~ composite yield on seasoned corporate bonds; or

27 (f) for other annuities with cash settlement options and guaranteed interest contracts with cash
28 settlement options valued on a change-in-fund basis, except as stated in subsection (1)(b), the average over
29 a period of 12 months, ending on June 30 of the calendar year of the change in the fund, of Moody's
30 ~~corporate bond yield average~~—monthly average ~~corporate~~ composite yield on seasoned corporate bonds.

(2) If Moody's ~~corporate bond yield average~~ monthly average ~~corporate~~ composite yield on seasoned corporate bonds is no longer published by Moody's investors service, inc., or if the national association of insurance commissioners determines that Moody's ~~corporate bond yield average~~ monthly average ~~corporate~~ composite yield on seasoned corporate bonds, as published by Moody's investors service, inc., is no longer appropriate for the determination of the reference interest rate, then an alternative method for determination of the reference interest rate adopted by the national association of insurance commissioners and approved by rule promulgated by the commissioner may be substituted."

Section 19. Section 33-2-531, MCA, is amended to read:

"33-2-531. Deposit of reserves -- domestic life insurers. (1) Domestic life insurers shall deposit and maintain on deposit, in securities and assets, with depositaries and subject to conditions as provided for in part 6 of this chapter, an amount not less than the reserves on its outstanding life insurance policies and annuity contracts, as valued under 33-2-521 through 33-2-526, minus policy loans.

(2) Annually on or before April 1, the insurer shall ~~so~~ deposit any additional ~~such~~ securities or assets required under subsection (1) and related to the increase of ~~such~~ the reserves, minus policy loans, during the calendar year next preceding, as determined from the insurer's annual statement as at December 31 of ~~such~~ the preceding year.

(3) A domestic stock life insurer may credit toward ~~such~~ the deposit the amount of any other deposit of the insurer held under part 6 of this chapter for the protection of its policyholders or of its policyholders and creditors.

(4) Deposits of the reserves of a domestic life insurer under this section ~~shall~~ must consist of securities and assets acquired and valued in accordance with parts 5 and 8 of this chapter.

(5) Real estate mortgage loans, and chattel mortgage loans, ~~and policy loans~~ may be made a part of the deposit by filing a verified statement of the loans with the commissioner, ~~which statement shall be.~~ The statement is subject to audit at all times by the commissioner. Nonnegotiable securities ~~where~~ deposited with the commissioner ~~shall~~ must be accompanied by transfer powers in due form. If the insurer uses real estate acquired under 33-2-832 as a deposit, then a deed of trust, mortgage, or other instrument sufficient to convey a security interest in ~~such~~ the real estate, in a form acceptable to the commissioner, ~~shall~~ must be completed in due form and recorded prior to being deposited with the commissioner.

(6) If default occurs in the payment of interest or principal of any deposited security and ~~such~~ the

1 default continues for a period of 120 days, the commissioner may declare ~~such~~ the security no longer
2 eligible for deposit under this section."

3
4 **Section 20.** Section 33-2-701, MCA, is amended to read:

5 **"33-2-701. Annual statement -- revocation or fine for failure to file -- penalty for perjury.** (1) Each
6 authorized insurer shall annually on or before March 1 file with the commissioner a full and true statement
7 of its financial condition, transactions, and affairs as of the preceding December 31 ~~preceding~~. The
8 statement must be in the general form and context as is required or not disapproved by the commissioner,
9 as is in current use for similar reports to states in general with respect to the type of insurer and kinds of
10 insurance to be reported upon, and as supplemented for additional information required by the
11 commissioner. The statement must be completed in accordance with the annual statement instructions and
12 the accounting practices and procedures manual of the national association of insurance commissioners.
13 The statement must be accompanied by an actuarial opinion attesting to the adequacy of the insurer's
14 reserves. The statement must be verified by the oath of the insurer's president or vice-president and
15 secretary or, if a reciprocal insurer, by the oath of the attorney-in-fact or its like officers if a corporation.
16 The commissioner may waive the verification under oath.

17 (2) (a) Each domestic insurer shall file electronic diskette versions of its annual and quarterly
18 financial statements with the national association of insurance commissioners. The filing date for
19 submission of the annual statement diskette is March 1. The filing dates for the quarterly statement
20 diskettes are as follows:

21 (i) the first calendar quarter filing is due May 15;

22 (ii) the second calendar quarter filing is due August 15; and

23 (iii) the third calendar quarter filing is due November 15.

24 (b) The commissioner may exempt insurers that operate only in Montana from these filing
25 requirements.

26 (2)(3) The statement of an alien insurer must relate only to its transactions and affairs in the United
27 States unless the commissioner requires otherwise. If the commissioner requires a statement as to an alien
28 insurer's affairs throughout the world, the insurer shall file the statement with the commissioner as soon
29 as reasonably possible. The statement must be verified by the insurer's United States manager or other
30 authorized officer.

1 ~~(3)~~(4) The commissioner may refuse to accept the fee for continuance of the insurer's certificate
2 of authority, as provided in 33-2-117, or may suspend or revoke the certificate of authority of any insurer
3 failing to file its annual statement when due or within an extension of time that the commissioner may
4 grant.

5 ~~(4)~~(5) Any director, officer or insurance producer, or employee of any company who subscribes
6 to, makes, or concurs in making or publishing any annual statement or any other statement required by law
7 knowing that the same to contain statement contains any material statement which is false shall be
8 punished by a fine of not more than \$1,000.

9 ~~(5)~~(6) At time of filing, the insurer shall pay to the commissioner the fee for filing its statement as
10 prescribed in 33-2-708.

11 ~~(6)~~(7) The commissioner may impose a fine not to exceed \$100 a day for each day after March
12 1 that an insurer fails to file the annual statement referred to in subsection (1). The fine may not exceed
13 a maximum of \$1,000."

14

15 **Section 21.** Section 33-2-705, MCA, is amended to read:

16 **"33-2-705. Report on premiums and other consideration -- tax.** (1) Each authorized insurer and
17 each formerly authorized insurer with respect to premiums received while an authorized insurer in this state
18 shall file with the commissioner, on or before March 1 each year, a report in a form prescribed by the
19 commissioner showing total direct premium income, including policy, membership, and other fees,
20 premiums paid by application of dividends, refunds, savings, savings coupons, and similar returns or credits
21 to payment of premiums for new or additional or extended or renewed insurance, charges for payment of
22 premium in installments, and all other consideration for insurance from all kinds and classes of insurance,
23 whether designated as a premium or otherwise, received by a life insurer or written by an insurer other than
24 a life insurer during the preceding calendar year on account of policies covering property, subjects, or risks
25 located, resident, or to be performed in Montana, with proper proportionate allocation of premium as to
26 property, subjects, or risks in Montana insured under policies or contracts covering property, subjects, or
27 risks located or resident in more than one state, after deducting from the total direct premium income
28 applicable cancellations, returned premiums, the unabsorbed portion of any deposit premium, the amount
29 of reduction in or refund of premiums allowed to industrial life policyholders for payment of premiums direct
30 to an office of the insurer, all policy dividends, refunds, savings, savings coupons, and other similar returns

1 paid or credited to policyholders with respect to the policies. As to title insurance, "premium" includes the
2 total charge for the insurance. A deduction may not be made of the cash surrender values of policies.
3 Considerations received on annuity contracts may not be included in total direct premium income and are
4 not subject to tax.

5 (2) Coincident with the filing of the tax report referred to in subsection (1), each insurer shall pay
6 to the commissioner a tax upon the net premiums computed at the rate of 2 3/4%.

7 (3) That portion of the tax paid under this section by an insurer on account of premiums received
8 for fire insurance must be separately specified in the report as required by the commissioner, for
9 apportionment as provided by law. When insurance against fire is included with insurance of property
10 against other perils at an undivided premium, the insurer shall make a reasonable allocation from the entire
11 premium to the fire portion of the coverage as must be stated in the report and as may be approved or
12 accepted by the commissioner.

13 (4) With respect to authorized insurers, the premium tax provided by this section must be payment
14 in full and in lieu of all other demands for any and all state, county, city, district, municipal, and school
15 taxes, licenses, fees, and excises of whatever kind or character, excepting only those prescribed by this
16 code, taxes on real and tangible personal property located in this state, and taxes payable under 50-3-109.

17 (5) The commissioner may suspend or revoke the certificate of authority of any insurer ~~which~~ that
18 fails to pay its taxes as required under this section.

19 (6) In addition to the penalty provided for in subsection (5), the commissioner may impose upon
20 an insurer who fails to pay the tax required under this section a fine of \$100 plus interest on the delinquent
21 amount at the annual interest rate ~~established in 31-1-107~~ of 12%.

22 (7) The commissioner may by rule provide a quarterly schedule for payment of portions of the
23 premium tax under this section during the year in which tax liability is accrued."
24

25 **Section 22.** Section 33-2-708, MCA, is amended to read:

26 "**33-2-708. Fees and licenses.** (1) Except as provided in 33-17-212(2), the commissioner shall
27 collect ~~in advance~~ and the persons served shall pay to the commissioner the following fees:

28 (a) certificates of authority:

29 (i) for filing applications for original certificates of authority, articles of incorporation, ~~except~~
30 original articles of incorporation of domestic insurers as provided in subsection (1)(b), and other charter

1	documents, bylaws, financial statement, examination report, power of attorney to the commissioner, and	
2	all other documents and filings required in connection with the application and for issuance of an original	
3	certificate of authority, if issued:	
4	(A) domestic insurers	\$ 600.00
5	(B) foreign insurers	600.00
6	(ii) annual continuation of certificate of authority	600.00
7	(iii) reinstatement of certificate of authority	25.00
8	(iv) amendment of certificate of authority	50.00
9	(b) articles of incorporation:	
10	(i) filing original articles of incorporation of a domestic insurer, exclusive of fees required to be paid	
11	by the corporation to the secretary of state	20.00
12	(ii) filing amendment of articles of incorporation, domestic and foreign insurers, exclusive of fees	
13	required to be paid to the secretary of state by a domestic corporation	25.00
14	(c) filing bylaws or amendment to bylaws when required	10.00
15	(d) filing annual statement of insurer, other than as part of application for original certificate of	
16	authority	25.00
17	(e) insurance producer's license:	
18	(i) application for original license, including issuance of license, if issued	15.00
19	(ii) appointment of insurance producer, each insurer, electronically filed	10.00
20	(iii) appointment of insurance producer, each insurer, nonelectronically filed	15.00
21	(iv) temporary license	15.00
22	(v) amendment of license ₂ {excluding additions to license} ₂ or reissuance of master license	15.00
23	(vi) termination of insurance producer, each insurer, electronically filed	10.00
24	(vii) termination of insurance producer, each insurer, nonelectronically filed	15.00
25	(f) nonresident insurance producer's license:	
26	(i) application for original license, including issuance of license, if issued	100.00
27	(ii) appointment of insurance producer, each insurer, electronically filed	10.00
28	(iii) appointment of insurance producer, each insurer, nonelectronically filed	15.00
29	(iv) annual renewal of license	10.00
30	(v) amendment of license ₂ {excluding additions to license} ₂ or reissuance of master license	15.00

1	(vi) termination of insurance producer, each insurer, electronically filed	10.00
2	(vii) termination of insurance producer, each insurer, nonelectronically filed	15.00
3	(g) examination, if administered by the commissioner, for license as insurance producer, each	
4	examination	15.00
5	(h) surplus lines insurance producer license:	
6	(i) application for original license and for issuance of license, if issued	50.00
7	(ii) annual renewal of license	50.00
8	(i) adjuster's license:	
9	(i) application for original license and for issuance of license, if issued	15.00
10	(ii) annual renewal of license	15.00
11	(j) insurance vending machine license, each machine, each year	10.00
12	<u>(k) motor club representative's license:</u>	
13	<u>(i) application for original license and issuance of license, if issued</u>	<u>15.00</u>
14	<u>(ii) annual renewal of license</u>	<u>15.00</u>
15	(k)(l) commissioner's certificate under seal, except when on certificates of authority or	
16	licenses	10.00
17	(l)(m) copies of documents on file in the commissioner's office, per page	.50
18	(m)(n) policy forms:	
19	(i) filing each policy form	25.00
20	(ii) filing each application, certificate, enrollment form, rider, endorsement, amendment, insert page,	
21	schedule of rates, and clarification of risks	10.00
22	(iii) maximum charge if policy and all forms submitted at one time or resubmitted for approval within	
23	180 days, <u>provided that all additional forms relate to the same policy</u>	100.00
24	(n)(o) applications for approval of prelicensing education courses:	
25	(i) reviewing initial application	150.00
26	(ii) periodic review	50.00
27	(2) The commissioner shall establish by rule fees commensurate with costs for filing documents	
28	and conducting the course reviews required by 33-17-1204 and 33-17-1205.	
29	(3) The commissioner shall establish by rule an annual accreditation fee to be paid by each	
30	domestic and foreign insurer when it submits a fee for annual continuation of its certificate of authority.	

1 (4)(a) Except as provided in subsection (4)(b), the commissioner shall promptly deposit with the
2 state treasurer to the credit of the general fund ~~of this state~~ all fines and penalties, those amounts received
3 pursuant to 33-2-311, 33-2-705, and 33-2-706, and any fees and examination and miscellaneous charges
4 that are collected by the commissioner pursuant to Title 33 and the rules adopted under Title 33, except
5 that all fees for filing documents and conducting the course reviews required by 33-17-1204 and
6 33-17-1205 must be deposited in the state special revenue fund pursuant to 33-17-1207.

7 (b) The accreditation fee required by subsection (3) must be turned over promptly to the state
8 treasurer who shall deposit the money in the state special revenue fund to the credit of the commissioner's
9 office. The accreditation fee funds must be used only to pay the expenses of the commissioner's office in
10 discharging the administrative and regulatory duties that are required to meet the minimum financial
11 regulatory standards established by the national association of insurance commissioners, subject to the
12 applicable laws relating to the appropriation of state funds and to the deposit and expenditure of money.
13 The commissioner is responsible for the proper expenditure of the accreditation money.

14 (5) All fees are considered fully earned when received. In the event of overpayment, only those
15 amounts in excess of \$10 will be refunded."

16

17 **Section 23.** Section 33-2-803, MCA, is amended to read:

18 **"33-2-803. General qualifications of investments.** (1) ~~No A~~ security or investment, other than real
19 and personal property acquired under 33-2-832, ~~shall be~~ is not eligible for acquisition unless it is interest
20 bearing or interest accruing or dividend or income paying, if not then in default in any respect, and the
21 insurer is entitled to receive for its exclusive account and benefit the interest or income accruing ~~thereon~~
22 on the security or investment. However, up to 3% of a company's total assets may be invested in
23 nondividend-paying common stock as described in 33-2-820.

24 (2) ~~No A~~ security or investment ~~shall be~~ is not eligible for purchase at a price above its market
25 value.

26 (3) ~~No A~~ provision of this part ~~shall~~ may not prohibit the acquisition by an insurer of other or
27 additional securities or property if received as a dividend or as a lawful distribution of assets or under a
28 lawful and bona fide agreement of bulk reinsurance, merger, or consolidation. Any investment ~~so~~ acquired
29 ~~which that~~ is not otherwise eligible under this part ~~shall~~ must be disposed of pursuant to 33-2-842 if
30 personal property or securities or pursuant to 33-2-841 if real property."

1 **Section 24.** Section 33-2-806, MCA, is amended to read:

2 **"33-2-806. Diversification of investments.** An insurer shall invest in or hold as admitted assets
3 categories of investments only within applicable limits as follows:

4 (1) An insurer ~~shall~~ may not, except with the consent of the commissioner, have at any one time
5 any combination of investments in or loans upon the security of the obligations, property, or securities of
6 any one person or insurer aggregating an amount exceeding 5% of the insurer's assets. This restriction ~~shall~~
7 does not apply as to general obligations of the United States of America or of any state or include policy
8 loans made under 33-2-825.

9 (2) An insurer ~~shall~~ may not invest in or hold at any one time more than 10% of the outstanding
10 voting stock of any corporation, except with the consent of the commissioner given with respect to voting
11 rights of preference stock during default of dividends. This provision does not apply as to stock of a
12 wholly-owned subsidiary of the insurer or to controlling stock of an insurer acquired under 33-2-821.

13 (3) An insurer, other than title insurer, shall invest and maintain invested funds not less in amount
14 than the minimum paid-in capital stock required under this code of a domestic stock insurer transacting like
15 kinds of insurance, only in cash and the securities provided for under the following sections: 33-2-811(1),
16 33-2-812, and 33-2-830.

17 (4) A life insurer shall also invest and keep invested its funds in an amount not less than the
18 reserves under its life insurance policies and annuity contracts, other than variable annuities, in force in
19 cash, ~~and/or the~~ in securities, in both cash and securities, or in investments provided for under 33-2-531.

20 (5) Except with the commissioner's consent, an insurer ~~shall~~ may not have invested at any one
21 time more than 20% of its assets in the class of securities described in 33-2-818, exclusive of obligations
22 of public utilities.

23 (6) An insurer may not invest and have invested at any one time in aggregate amount ~~not~~ more
24 than ~~10%~~ 15% of its assets in all stocks under 33-2-820 and 33-2-821. Determination of the amount
25 ~~which that~~ an insurer has invested in common stocks for the purposes of this provision ~~shall~~ must be based
26 on the cost of ~~such~~ the stocks to the insurer. This provision ~~shall~~ does not apply as to stock of a controlled
27 or subsidiary insurance corporation or other corporations under 33-2-821 and 33-2-822.

28 (7) Except with the commissioner's consent, an insurer may not have invested at any one time
29 more than 5% of its assets in securities allowed under 33-2-824.

30 (8) Except with the commissioner's consent, an insurer ~~shall~~ may not have invested at any one

time more than 10% of its assets in the class of securities described in any one of the following sections:
33-2-814, 33-2-819, and 33-2-823.

(9) Limits as to investments in the category of real estate shall be as provided in 33-2-832. Other specific limits shall apply as stated in the sections dealing with other respective kinds of investments."

Section 25. Section 33-2-820, MCA, is amended to read:

"33-2-820. Common stocks. An insurer may invest in nonassessable common stocks, other than insurance stocks, of any solvent corporation existing under the laws of the United States of America or of Canada or any state or province thereof ~~if cash or stock dividends have been earned and paid on its common stock in each of the 5 fiscal years preceding such acquisition and if, further, all prior obligations or preference stock of such corporation, if any, are eligible for investment under this part. If the issuing corporation has not been in legal existence for the whole of the 5 preceding fiscal years but was formed as a consolidation or merger of two or more businesses, the test of eligibility for investment of its common stock under this section shall be based upon consolidation pro forma statements of the predecessor or constituent institutions.~~"

Section 26. Section 33-2-1111, MCA, is amended to read:

"33-2-1111. Registration of insurers -- requisites -- termination. (1) ~~Every~~ An insurer ~~which is~~ authorized to do business in this state ~~and which~~ that is a member of an insurance holding company system shall register with the commissioner, except that a foreign insurer subject to disclosure requirements and standards adopted by statute or regulation in the jurisdiction of its domicile ~~which~~ that are substantially similar to those contained in this section is not required to register. Any insurer ~~which is~~ subject to registration under this section shall register within 15 days after it ~~becomes~~ becoming subject to registration, unless the commissioner for good cause ~~shown~~ extends the time for registration, ~~and then within the extended time~~. The commissioner may require any authorized insurer ~~which~~ that is a member of a holding company system ~~which~~ that is not subject to registration under this section to furnish a copy of the registration statement or other information filed by the insurance company with the insurance regulatory authority of ~~domiciliary~~ in the jurisdiction where the company is domiciled.

(2) ~~Every~~ An insurer subject to registration shall file with the commissioner, on or before April 30 each year, a registration statement on a form provided by the commissioner, ~~which~~ that must contain

1 current information about:

2 (a) the capital structure, general financial condition, ownership, and management of the insurer and
3 any person controlling the insurer;

4 (b) the identity of every member of the insurance holding company system;

5 (c) ~~the following agreements in force, existing relationships subsisting, and~~ transactions currently
6 outstanding between the insurer and its affiliates, and the following agreements that are in force:

7 (i) loans, other investments, or purchases, sales, or exchanges of securities of the affiliates by the
8 insurer or of the insurer by its affiliates;

9 (ii) purchases, sales, or exchanges of assets;

10 (iii) transactions not in the ordinary course of business;

11 (iv) guaranties or undertakings for the benefit of an affiliate ~~which~~ that result in an actual
12 contingent exposure of the insurer's assets to liability, other than insurance contracts entered into in the
13 ordinary course of the insurer's business;

14 (v) ~~all~~ management and service contracts and ~~all~~ cost-sharing arrangements, ~~other than cost~~
15 ~~allocation arrangements based upon generally accepted accounting principles;~~

16 (vi) reinsurance agreements covering all or substantially all of one or more lines of insurance of the
17 ceding company;

18 (vii) dividends and other distributions to shareholders; and

19 (viii) consolidated tax allocation agreements;

20 (d) ~~any~~ a pledge of the insurer's stock, including stock of a subsidiary or controlling affiliate for a
21 loan made to a member of the insurance holding company system;

22 (e) all matters concerning transactions between registered insurers and any affiliates as may be
23 included from time to time in ~~any~~ registration forms adopted or approved by the commissioner.

24 (3) A registration statement must contain a summary outlining each item in the current registration
25 statement that represents a change from the prior registration statement.

26 (4) Information need not be disclosed on the registration statement filed pursuant to subsection
27 (2) if the information is not material for the purposes of this section. Unless the commissioner by rule or
28 order provides otherwise, sales, purchases, exchanges, loans or extensions of credit, or investments
29 involving 1/2 of 1% or less of an insurer's admitted assets as of the prior December 31 ~~next preceding~~ are
30 not material for purposes of this section.

1 (5) A person within an insurance holding company system subject to registration shall provide
2 complete and accurate information to an insurer if the information is reasonably necessary to enable the
3 insurer to comply with Title 33, chapter 2, part 11.

4 (6) Each registered insurer shall keep current the information required to be disclosed in its
5 registration statement by reporting all material changes or additions on amendment forms provided by the
6 commissioner within 15 days after the end of the month in which it learns of each change or addition.

7 (7) The commissioner shall terminate the registration of any insurer ~~which~~ that demonstrates that
8 it no longer is a member of an insurance holding company system.

9 (8) The commissioner may require or allow two or more affiliated insurers subject to registration
10 under this section to file a consolidated registration statement or consolidated reports amending their
11 consolidated registration statement or their individual registration statements.

12 (9) The commissioner may allow an insurer ~~which~~ that is authorized to do business in this state
13 and ~~which~~ that is part of an insurance holding company system to register on behalf of any affiliated insurer
14 which is required to register under subsection (1) and to file all information and material required to be filed
15 under this section."

16

17 **Section 27.** Section 33-2-1201, MCA, is amended to read:

18 "**33-2-1201. Limit of risk.** (1) An insurer may not retain any risk on any one subject of insurance,
19 whether located or to be performed in this state or elsewhere, in an amount exceeding 10% of its surplus
20 to policyholders.

21 (2) A "subject of insurance" for the purposes of this section, as to insurance against fire and
22 hazards other than windstorm, earthquake, or other catastrophe hazards, includes all properties insured by
23 the same insurer which are customarily considered by underwriters to be subject to loss or damage from
24 the same fire or the same occurrence of the other hazard insured against.

25 (3) Reinsurance ceded as authorized by this part must be deducted in determining risk retained.
26 As to surety risks, deduction must also be made of the amount assumed by any established incorporated
27 cosurety and the value of any security deposited, pledged, or held subject to the surety's consent and for
28 the surety's protection.

29 (4) As to alien insurers, this section only relates to risks and surplus to policyholders of the
30 insurer's United States branch.

(5) "Surplus to policyholders" for the purposes of this section, in addition to the insurer's capital and surplus, is considered to include any voluntary reserves which are not required pursuant to law and are determined from the last sworn statement of the insurer on file with the commissioner or by the last report of examination of the insurer, whichever is the more recent at time of assumption of risk.

(6) This section does not apply to life or disability insurance, title insurance, insurance of wet marine and transportation risks, workers' compensation insurance, employer's liability coverages, ~~sprinklered risks~~, or any policy or type of coverage as to which the maximum possible loss to the insurer is not readily ascertainable on issuance of the policy."

Section 28. Section 33-2-1216, MCA, is amended to read:

"33-2-1216. Credit allowed domestic ceding insurer. (1) Credit for reinsurance is allowed to a domestic ceding insurer as either an asset or a deduction from liability on account of reinsurance ceded only when the reinsurer meets the requirements of subsection (2), (3), (4), (5), or (6). If the requirements of subsection (4) or (5) are met, the requirements of subsection (7) must also be met.

(2) Credit must be allowed when the reinsurance is ceded to an assuming insurer that is licensed to transact insurance or reinsurance in this state.

(3) Credit must be allowed when the reinsurance is ceded to an assuming insurer that is accredited as a reinsurer in this state. Credit may not be allowed a domestic ceding insurer if the assuming insurer's accreditation has been revoked by the commissioner after notice and hearing. An accredited reinsurer is one that:

(a) files with the commissioner evidence of its submission to this state's jurisdiction;

(b) submits to this state's authority to examine its books and records;

(c) is licensed to transact insurance or reinsurance in at least one state or, in the case of a United States branch of an alien assuming insurer, is entered through and licensed to transact insurance or reinsurance in at least one state;

(d) files annually with the commissioner a copy of its annual statement filed with the insurance department of its state of domicile and a copy of its most recent audited financial statement and either:

(i) maintains a surplus with regard to policyholders in an amount that is not less than \$20 million and whose accreditation has not been denied by the commissioner within 90 days of its submission; or

(ii) maintains a surplus with regard to policyholders in an amount less than \$20 million and whose

1 accreditation has been approved by the commissioner.

2 (4) (a) Subject to subsection (4)(b), credit must be allowed when:

3 (i) the reinsurance is ceded to an assuming insurer that is domiciled and licensed in or, in the case
4 of a United States branch of an alien assuming insurer, is entered through a state that employs standards
5 regarding credit for reinsurance substantially similar to those applicable under this statute; and

6 (ii) the assuming insurer or the United States branch of an alien assuming insurer:

7 (A) maintains a surplus with regard to policyholders in an amount not less than \$20 million; and

8 (B) submits to the authority of this state to examine its books and records.

9 (b) The requirement of subsection (4)(a)(i) does not apply to reinsurance ceded and assumed
10 pursuant to pooling arrangements among insurers in the same holding company system.

11 (5) (a) Credit must be allowed when the reinsurance is ceded to an assuming insurer that maintains
12 a trust fund in a qualified United States financial institution for the payment of the valid claims of its United
13 States policyholders and ceding insurers and their assigns and successors in interest. The assuming insurer
14 shall report annually to the commissioner information substantially the same as that required to be reported
15 on the NAIC annual statement form by licensed insurers to enable the commissioner to determine the
16 sufficiency of the trust fund.

17 (b) (i) In the case of a single assuming insurer, the trust must consist of a trustee account
18 representing the assuming insurer's liabilities attributable to business written in the United States, and in
19 addition, the assuming insurer shall maintain a surplus with the trustee of not less than \$20 million.

20 (ii) In the case of a group, ~~of~~ including incorporated and individual unincorporated underwriters,
21 the trust must consist of a trustee account representing the group's liabilities attributable to business
22 written in the United States, and in addition, the group shall maintain a surplus with the trustee of which
23 \$100 million must be held jointly for the benefit of United States ceding insurers of any member of the
24 group.

25 (iii) The incorporated members of the group, as group members, may not be engaged in a business
26 other than underwriting as members of the group and are subject to the same level of solvency regulation
27 and control by the insurance regulator as the unincorporated members. The group shall make available to
28 the commissioner an annual certification of the solvency of each underwriter by the ~~group's domiciliary~~
29 insurance regulator and the independent public accountants in the jurisdiction where the underwriter is
30 domiciled and its independent public accountants.

1 ~~iii~~(iv) In the case of a group of incorporated insurers under common administration:

2 (A) the provisions of subsection ~~(5)(b)iii(B)~~ (5)(b)(iv)(B) apply, to the group that:

3 (I) complies with the reporting requirements contained in subsection (5)(a);

4 (II) has continuously transacted an insurance business outside the United States for at least 3 years
5 immediately prior to making application for accreditation;

6 (III) submits to this state's authority to examine its books and records and bears the expense of the
7 examination; and

8 (IV) has aggregate policyholders' surplus of \$10 billion;

9 (B) (I) the trust must be in an amount equal to the group's several liabilities attributable to business
10 ceded by United States ceding insurers to any member of the group pursuant to reinsurance contracts
11 issued in the name of the group;

12 (II) the group shall maintain a joint surplus with a trustee of which \$100 million is held jointly for
13 the benefit of United States ceding insurers of any member of the group as additional security for any
14 liabilities; and

15 (III) each member of the group shall make available to the commissioner an annual certification of
16 the member's solvency by the ~~member's domiciliary regulator and its independent public accountant~~
17 insurance regulator and the independent public accountants in the jurisdiction where the underwriter is
18 domiciled.

19 (c) The trust must be established in a form approved by the commissioner. The trust instrument
20 must provide that contested claims are valid and enforceable upon the final order of any court of competent
21 jurisdiction in the United States. The trust must vest legal title to its assets in the trustees of the trust for
22 its United States policyholders and ceding insurers and their assigns and successors in interest. The trust
23 and the assuming insurer are subject to examination as determined by the commissioner. The trust
24 described in this subsection (c) must remain in effect for as long as the assuming insurer has outstanding
25 obligations due under the reinsurance agreements subject to the trust.

26 (d) No later than February 28 of each year, the trustees of the trust shall report to the
27 commissioner in writing setting forth the balance of the trust and listing the trust's investments at the end
28 of the preceding year. The trustees shall certify the date of termination of the trust, if planned, or certify
29 that the trust may not expire prior to the following December 31.

30 (6) Credit must be allowed when the reinsurance is ceded to an assuming insurer that does not

1 meet the requirements of subsection (2), (3), (4), or (5) but only with respect to the insurance of risks
2 located in a jurisdiction in which the reinsurance is required by applicable law or regulation of that
3 jurisdiction.

4 (7) (a) If the assuming insurer is not licensed or accredited to transact insurance or reinsurance in
5 this state, the credit permitted by subsections (4) and (5) may not be allowed unless the assuming insurer
6 agrees in the reinsurance agreements:

7 (i) that in the event of the failure of the assuming insurer to perform its obligations under the terms
8 of the reinsurance agreement, the assuming insurer, at the request of the ceding insurer, will:

9 (A) submit to the jurisdiction of any court of competent jurisdiction in any state of the United
10 States;

11 (B) comply with all requirements necessary to give the court jurisdiction; and

12 (C) abide by the final decision of the court or of any appellate court in the event of an appeal; and

13 (ii) to designate the commissioner or a designated attorney as its attorney upon whom may be
14 served any lawful process in any action, suit, or proceeding instituted by or on behalf of the ceding
15 company.

16 (b) Subsection (7)(a)(i) is not intended to conflict with or override the obligation of the parties to
17 a reinsurance agreement to arbitrate their disputes if an obligation is created in the agreement."

18
19 **Section 29.** Section 33-2-1217, MCA, is amended to read:

20 **"33-2-1217. Reduction of liability for reinsurance ceded by domestic insurer to assuming insurer**

21 **-- definition.** A reduction from liability for the reinsurance ceded by a domestic insurer to an assuming
22 insurer not meeting the requirements of 33-2-1216 must be allowed in an amount not exceeding the
23 liabilities carried by the ceding insurer. The reduction must be in the amount of funds held by or on behalf
24 of the ceding insurer, including funds held in trust for the ceding insurer:

25 (1) under a reinsurance contract with the assuming insurer as security for the payment of
26 obligations under the contract if the security is held in the United States subject to withdrawal solely by
27 and under the exclusive control of the ceding insurer; or

28 (2) in the case of a trust, in a qualified United States financial institution. This security may be in
29 the form of:

30 (a) cash;

1 (b) securities listed by the securities valuation office of the NAIC and qualifying as admitted assets;

2 (c) clean, irrevocable, unconditional letters of credit that are issued or confirmed by a qualified
3 United States financial institution no later than December 31 of the year for which filing is being made and
4 that are in the possession of the ceding company on or before the filing date of its annual statement.
5 Letters of credit meeting applicable standards of issuer acceptability as of the dates of their issuance or
6 confirmation must, notwithstanding the issuing or confirming institution's subsequent failure to meet
7 applicable standards of issuer acceptability, continue to be acceptable as security until their expiration,
8 extension, renewal, modification, or amendment, whichever occurs first.

9 (d) any other form of security acceptable to the commissioner.

10 (3) For the purposes of subsection (2)(c), a "qualified United States financial institution" means an
11 institution that:

12 (a) is organized or, in the case of a United States office of a foreign banking organization, licensed
13 under the laws of the United States or any of its states;

14 (b) is regulated, supervised, and examined by United States federal or state authorities with
15 regulatory authority over banks and trust companies; and

16 (c) has been determined by either the commissioner or the securities valuation office of the national
17 association of insurance commissioners to meet the standards of financial condition and standing that are
18 considered necessary and appropriate to regulate the quality of financial institutions whose letters of credit
19 will be acceptable to the commissioner.

20 (4) For the purposes of this part, except for subsection (2)(c), "qualified United States financial
21 institution" means, with respect to institutions eligible to act as a fiduciary of a trust, an institution that:

22 (a) is organized or, in the case of a United States branch or agency office of a foreign banking
23 corporation, licensed under the laws of the United States or any of its states and that has been granted
24 authority to operate with fiduciary powers; and

25 (b) is regulated, supervised, and examined by federal or state authorities having regulatory authority
26 over banks and trust companies.

27 (5) The commissioner may adopt rules implementing the provisions of 33-2-307, 33-2-708, and
28 33-2-806."

29
30 Section 30. Section 33-2-1218, MCA, is amended to read:

1 **"33-2-1218. Reinsurance agreements affected.** Sections 33-2-1216 and 33-2-1217 apply to all
2 cessions after October 1, 1993, under reinsurance agreements that have had an inception, anniversary, or
3 renewal date on or ~~before~~ after April 1, 1993."

4
5 **Section 31.** Section 33-2-1510, MCA, is amended to read:

6 **"33-2-1510. Minimum standards.** Unless there is a written contract between a controlling producer
7 and a controlled insurer specifying the responsibilities of each party, the controlled insurer may not accept
8 business from the controlling producer and the controlling producer may not place business with the
9 controlled insurer. The contract must be approved by the board of directors of the controlled insurer and
10 must contain the following minimum provisions:

11 (1) The controlled insurer may terminate the contract for cause, upon written notice to the
12 controlling producer. The controlled insurer shall suspend the authority of the controlling producer to write
13 business during the pendency of any dispute regarding the cause for the termination.

14 (2) The controlling producer shall render to the controlled insurer accounts detailing all material
15 transactions, including information necessary to support all commissions, charges, and other fees received
16 by or owing to the controlling producer.

17 (3) On at least a monthly basis, the controlling producer shall remit to the controlled insurer all
18 funds due under the terms of the contract. The due date must be fixed so that premiums or installments
19 of premiums collected must be remitted no later than 90 days after the effective date of any policy placed
20 with the controlled insurer under the contract.

21 (4) In accordance with the provisions of this title, all funds collected for the controlled insurer's
22 account must be held by the controlling producer in a fiduciary capacity, in one or more appropriately
23 identified bank accounts in banks that are members of the federal reserve system. However, funds of a
24 controlling producer not required to be licensed in this state must be maintained in compliance with the
25 requirements of the jurisdiction in which the controlling producer's domiciliary jurisdiction producer is
26 domiciled.

27 (5) The controlling producer shall maintain separately identifiable records of business written for
28 the controlled insurer.

29 (6) The contract may not be assigned in whole or in part by the controlling producer.

30 (7) The controlled insurer shall provide the controlling producer with its underwriting standards,

1 rules, procedures, manuals setting forth the rates to be charged, and the conditions for the acceptance or
2 rejection of risks. The controlling producer shall adhere to the standards, rules, procedures, rates, and
3 conditions. The standards, rules, procedures, rates, and conditions must be the same as those applicable
4 to comparable business placed with the controlled insurer by a producer other than the controlling producer.

5 (8) The rates and terms of the controlling producer's commissions, charges, or other fees and the
6 purposes of those commissions, charges, or fees must be contained in the contract. The rates of the
7 controlling producer's commissions, charges, and other fees may not be greater than those applicable to
8 comparable business placed with the controlled insurer by producers other than controlling producers. For
9 purposes of subsection (7) and this subsection, examples of "comparable business" include the same lines
10 of insurance, same kinds of insurance, same kinds of risks, similar policy limits, and similar quality of
11 business.

12 (9) If the contract provides that on insurance business placed with the controlled insurer, the
13 controlling producer is to be compensated contingent upon the controlled insurer's profits on that business,
14 then the compensation may not be determined and paid until at least 5 years after the premiums on liability
15 insurance are earned and at least 1 year after the premiums are earned on any other insurance. The
16 commissions may not be paid until the adequacy of the controlled insurer's reserves on remaining claims
17 has been independently verified pursuant to 33-2-1512.

18 (10) The rates and terms of the controlling producer's commissions, charges, or other fees and
19 the purposes of those commissions, charges, or fees must be contained in the contract. The controlled
20 insurer may establish a different limit for each line or subline of business. The controlled insurer shall notify
21 the controlling producer when the applicable limit is approached and may not accept business from the
22 controlling producer if the limit is reached. The controlling producer may not place business with the
23 controlled insurer if it has been notified by the controlled insurer that the limit has been reached.

24 (11) The controlling producer may negotiate but may not bind reinsurance on behalf of the
25 controlled insurer on business that the controlling producer places with the controlled insurer, except that
26 the controlling producer may bind facultative reinsurance contracts pursuant to obligatory facultative
27 agreements if the contract with the controlled insurer contains underwriting guidelines. For reinsurance
28 assumed and ceded, the guidelines must include a list of reinsurers with which the automatic agreements
29 are in effect, the coverages and amounts or percentages that may be reinsured, and commission
30 schedules."

1 **Section 32.** Section 33-2-1605, MCA, is amended to read:

2 **"33-2-1605. Penalties and liabilities.** (1) If, after a hearing conducted in accordance with Title 33,
3 chapter 1, part 7, the commissioner finds that a person has violated any provision of this part, the
4 commissioner may order:

5 (a) a penalty in an amount of \$5,000 for each separate violation;

6 (b) revocation or suspension of the producer's license; and

7 (c) the managing general agent to reimburse the insurer, the rehabilitator, or a liquidator of the
8 insurer for any losses incurred by the insurer caused by a violation of this part committed by the managing
9 general agent.

10 (2) An order of the commissioner pursuant to subsection (1) is subject to judicial review pursuant
11 to 33-1-711.

12 (3) This section does not limit the power of the commissioner to impose any other penalty provided
13 in this title.

14 (4) This part does not limit the rights of policyholders, claimants, or ~~auditors~~ creditors."

15
16 **Section 33.** Section 33-3-431, MCA, is amended to read:

17 **"33-3-431. Borrowed surplus.** (1) A domestic stock or mutual insurer may borrow money to
18 defray the expenses of its organization, to provide it with surplus funds, or for any purpose of its business,
19 upon a written agreement that ~~such the~~ money is required to be repaid only out of the insurer's surplus in
20 excess of that stipulated in ~~such the~~ agreement. The agreement may provide for interest at a rate ~~no not~~
21 greater than the rate established in 25-9-205, ~~which interest shall or shall not constitute a liability of the~~
22 ~~insurer as to its funds other than such excess of surplus, as~~ and whether the interest constitutes a liability
23 of the insurer must be stipulated in the agreement. ~~No A~~ commission or promotion expense ~~shall~~ may not
24 be paid in connection with ~~any such a~~ a loan of the type described in this section.

25 (2) Money ~~so~~ borrowed, together with the interest ~~thereon~~ if ~~so~~ stipulated in the agreement, ~~shall~~
26 does not form a part of the insurer's legal liabilities except as to its surplus in excess of the amount ~~thereof~~
27 stipulated in the agreement or ~~be~~ the basis of any setoff; ~~but~~ However, until the money or interest, or
28 both, are repaid, financial statements filed or published by the insurer ~~shall~~ must show as a footnote ~~thereto~~
29 the amount ~~thereof~~ then unpaid together with any interest ~~thereon~~ accrued but unpaid.

30 (3) ~~Any such A~~ A loan of this type to a mutual or stock insurer ~~shall be~~ is subject to the

1 commissioner's approval. The insurer shall, in advance of the loan, file with the commissioner a statement
2 of the purpose of the loan and a copy of the proposed loan agreement. The loan and agreement ~~shall be~~
3 ~~deemed~~ are approved unless within 15 days after ~~date of such~~ filing the insurer is notified of the
4 commissioner's disapproval and ~~the reasons therefor~~ reasons for the disapproval. The commissioner shall
5 disapprove any proposed loan or agreement if ~~he~~ the commissioner finds the loan is unnecessary or
6 excessive for the purpose intended or that the terms of the loan agreement are not fair and equitable to the
7 parties, and to other similar lenders, if any, to the insurer, or that the information ~~so~~ filed by the insurer is
8 inadequate.

9 (4) ~~Any such~~ A loan to a mutual or stock insurer or a substantial portion ~~thereof of the loan~~ shall
10 must be repaid by the insurer when it is no longer reasonably necessary for the purpose originally intended.
11 ~~No repayment of such loan shall~~ Repayment of either principal or interest on the loan may not be made by
12 a mutual or stock insurer unless ~~in advance~~ approved in advance by the commissioner.

13 (5) This section ~~shall~~ does not apply to loans obtained by the insurer in the ordinary course of
14 business from banks and other financial institutions or to loans secured by pledge or mortgage of assets."

15
16 **Section 34.** Section 33-4-202, MCA, is amended to read:

17 "**33-4-202. Declaration of intention to incorporate -- articles of incorporation -- fee.** (1) The
18 individuals proposing to form a farm mutual insurer as referred to in 33-4-201 shall file with the
19 commissioner:

20 (a) a declaration of their intention to form ~~such a~~ the corporation, ~~which declaration shall be~~ signed
21 by at least 100 incorporators if a proposed state mutual insurer or by at least 25 incorporators if a proposed
22 county mutual insurer; and

23 (b) proposed articles of incorporation executed in ~~quadruplicate~~ triplicate by three or more of the
24 incorporators and acknowledged by each before a person authorized to take and verify acknowledgments
25 of conveyance of real property.

26 (2) The articles of incorporation ~~shall~~ must state:

27 (a) the name of the corporation. If a state mutual insurer, the words "farm mutual" must be a part
28 of the name; if a county mutual insurer, the name ~~shall~~ must contain the words "farm mutual" or "rural
29 mutual" together with the name of the county ~~wherein is to be located~~ in which its principal place of
30 business is to be located. The name ~~shall~~ may not be so similar to one already used by a corporation in

1 this state as to be misleading.

2 (b) if a county mutual insurer, the name of the county or counties in which the corporation is to
3 transact insurance and the address where its principal business office will be located;

4 (c) if a state mutual insurer, the location of its principal business office, which ~~office~~ must be
5 located in this state;

6 (d) the objects and purposes for which the corporation is formed;

7 (e) whether it intends to transact business on the cash premium plan or the assessment plan;

8 (f) the duration of its existence, which may be perpetual;

9 (g) the number of its directors, which ~~shall~~ may not be less than 5 or more than 11; ~~also, and the~~
10 names and addresses of the members of the initial board of directors appointed to manage the affairs of
11 the corporation until the first annual meeting of the members and ~~until their~~ successors are elected and
12 qualified;

13 (h) ~~such~~ other provisions, not inconsistent with law, ~~deemed~~ considered appropriate by the
14 incorporators;

15 (i) the names, residences, and addresses of the incorporators and the value of ~~the~~ their property
16 ~~desired to be insured owned by each~~ in the county or counties where the operations of the corporation are
17 to be carried on.

18 (3) At the time of filing of the articles of incorporation as provided in subsection (1) ~~above~~, the
19 incorporators shall pay to the commissioner a filing fee of \$10. The commissioner shall deposit ~~all such the~~
20 fees with the state treasurer to the credit of the general fund ~~of this state.~~"

21
22 **Section 35.** Section 33-4-203, MCA, is amended to read:

23 **"33-4-203. Approval of articles -- commencement of corporate existence.** (1) ~~Upon receipt of~~
24 ~~proposed articles of incorporation, the commissioner shall forward the proposed articles of incorporation~~
25 ~~to the attorney general for examination. If the attorney general~~ commissioner finds the proposed articles
26 of incorporation to be in accordance with the provisions of this chapter and not in conflict with the
27 constitution and laws of the United States of America or of this state, the ~~attorney general~~ commissioner
28 shall make a certificate of the facts ~~and return it with the proposed articles to the commissioner.~~

29 (2) If the commissioner considers the name of the proposed corporation to be so similar to one
30 already appropriated by another company or corporation as to be likely to mislead the public, the

1 commissioner shall reject the name applied for and shall notify the incorporators of the rejection.

2 (3) When the proposed articles of incorporation have been approved by the ~~attorney general~~
3 commissioner, the commissioner shall ~~likewise~~ endorse the commissioner's approval upon each set of the
4 articles and forward ~~four~~ three sets of articles to the incorporators. The incorporators shall file one of the
5 sets of articles with the secretary of state, one set with the commissioner bearing the certification of the
6 secretary of state, and one set with the county clerk of the county in which the principal place of business
7 of the corporation is located and shall pay to the secretary of state and the county clerk the customary
8 filing fees. The remaining set of articles must be made a part of the corporation's records.

9 (4) The corporation has legal existence upon the approval of the articles by the ~~attorney general~~
10 ~~and the commissioner~~ and completion of the filings referred to in subsection (3), but it may not transact
11 business as an insurer until it has fulfilled the requirements for and has obtained a certificate of authority
12 as provided in 33-4-505."

13
14 **Section 36.** Section 33-5-401, MCA, is amended to read:

15 **"33-5-401. Surplus funds required.** (1) A domestic reciprocal insurer ~~hereunder formed~~ subject
16 to this part, if it has otherwise complied with the applicable provisions of this code, may be authorized to
17 transact insurance if it has and ~~thereafter~~ maintains surplus funds as follows:

18 (a) to transact property insurance, surplus funds of not less than \$400,000;

19 (b) to transact casualty insurance; ~~other than workers' compensation, surplus funds of not less~~
20 ~~than \$400,000.~~

21 (i) including authority for workers' compensation insurance, surplus funds of not less than
22 \$600,000; or

23 (ii) excluding authority for workers' compensation insurance, surplus funds of not less than
24 \$400,000.

25 (2) In addition to surplus funds required to be maintained under subsection (1) ~~above~~, the insurer
26 ~~shall~~ must have, when first ~~so~~ authorized, expendable surplus in the same amount as required of a like
27 foreign reciprocal insurer under 33-2-110.

28 (3) A domestic reciprocal insurer may be authorized to transact additional kinds of insurance if it
29 has otherwise complied with the provisions of this code ~~therefor~~ for the additional kinds of insurance and
30 ~~possesses and so~~ maintains surplus funds in an amount equal to the minimum capital stock required of a

1 stock insurer for authority to transact a like combination of kinds of insurance."

2
3 **Section 37.** Section 33-7-117, MCA, is amended to read:

4 **"33-7-117. Scope -- provisions applicable.** (1) Except as provided in subsection (2), societies are
5 governed by this chapter and are exempt from all other provisions of the insurance laws of this state, not
6 only in governmental relations with the state but for every other purpose. The provisions of a law enacted
7 after January 1, 1992, do not apply to fraternal benefit societies unless expressly made applicable by the
8 provisions of the law.

9 (2) In addition to the provisions of this chapter, the provisions of chapter 1, parts 1 through 4 and
10 7; 33-2-104; 33-2-107; 33-2-112; chapter 2, part 13; 33-3-308; 33-15-502; ~~and~~ chapters 17, 18, 20, and
11 22; and [sections 78 through 81] apply to fraternal benefit societies to the extent applicable and to the
12 extent not in conflict with the provisions of this chapter and the reasonable implications of this chapter."

13
14 **Section 38.** Section 33-10-201, MCA, is amended to read:

15 **"33-10-201. Short title, purpose, scope, and construction.** (1) This part ~~shall be known and~~ may
16 be cited as the "Montana Life and Health Insurance Guaranty Association Act".

17 (2) The purpose of this part is to protect policyowners, insureds, beneficiaries, annuitants, payees,
18 and assignees of life insurance policies, health insurance policies, annuity contracts, and supplemental
19 contracts, subject to certain limitations, against failure in the performance of contractual obligations due
20 to the impairment of the insurer issuing the policies or contracts.

21 (3) To provide this protection:

22 (a) an association of insurers is created to enable the guaranty of payment of benefits and of
23 continuation of coverages;

24 (b) members of the association are subject to assessment to provide funds to carry out the purpose
25 of this part; and

26 (c) the association is authorized to assist the commissioner, in the prescribed manner, in the
27 detection and prevention of insurer impairments.

28 (4) This part applies to direct, nongroup life, health, annuity, and supplemental policies or
29 contracts, to certificates under direct group policies and contracts, and to unallocated annuity contracts
30 issued by member insurers, except as limited by this part. Annuity contracts and certificates under group

1 annuity contracts include but are not limited to guaranteed investment contracts, deposit administration
2 contracts, unallocated funding agreements, allocated funding agreements, structured settlement
3 agreements, lottery contracts, and any immediate or deferred annuity contracts.

4 (5) This part provides coverage for ~~covered~~ policies and contracts specified in subsection (6):

5 (a) to persons who are owners of or certificate holders under covered policies or, in the case of
6 unallocated annuity contracts, to the persons who are contract holders and who if the persons:

7 (i) are residents; or

8 (ii) are not residents, but only under all of the following conditions:

9 (A) the insurers that issued the policies are domiciled in this state;

10 (B) the insurers have not held a license or certificate of authority in the state in which the persons
11 reside;

12 (C) the state has an association similar to the association created under this part; and

13 (D) the persons are not eligible for coverage by that association; and

14 (b) to persons who, regardless of where they reside, except for nonresident certificate holders
15 under group policies or contracts, are the beneficiaries, assignees, or payees of the persons covered under
16 subsection (5)(a).

17 (6) This part covers persons specified in subsection (5)(a) for direct, nongroup life, health, annuity,
18 and supplemental policies and contracts, for certificates under direct group policies and contracts, and for
19 unallocated annuity contracts issued by member insurers, except as limited by this part. Annuity contracts
20 and certificates under group annuity contracts include but are not limited to guaranteed investment
21 contracts, deposit administration contracts, allocated and unallocated funding agreements, structured
22 settlement agreements, lottery contracts, and immediate or deferred annuity contracts. This part does not
23 apply to:

24 (a) ~~any~~ policies or contracts or any part of the policies or contracts under which the risk is borne
25 by the policyholder;

26 (b) ~~any~~ a policy or contract or part of the policy or contract assumed by the impaired insurer under
27 a contract of reinsurance, other than reinsurance for which assumption certificates have been issued;

28 (c) any portion of a policy or contract to the extent that the rate of interest on which it is based:

29 (i) averaged over the period of 4 years prior to the date on which the association becomes
30 obligated with respect to the policy or contract, exceeds a rate of interest determined by subtracting 2

percentage points from Moody's corporate bond yield average averaged for that same 4-year period or for the lesser period if the policy or contract was issued less than 4 years before the association became obligated; and

(ii) on and after the date on which the association becomes obligated with respect to the policy or contract, exceeds the rate of interest determined by subtracting 3 percentage points from Moody's corporate bond yield average as is most recently available;

(d) any plan or program of an employer, association, or similar entity to provide life, health, or annuity benefits to its employees or members to the extent that the plan or program is self-funded or uninsured, including but not limited to benefits payable by an employer, association, or similar entity under:

(i) a multiple employer welfare arrangement, as defined in section 514 of the Employee Retirement Income Security Act of 1974, as amended;

(ii) a minimum premium group insurance plan;

(iii) a stop-loss group insurance plan; or

(iv) an administrative services only contract;

(e) any portion of a policy or contract to the extent that it provides dividends or experience rating credits or provides that any fees or allowances be paid to any person, including the policy or contract holder, in connection with the service to or administration of the policy or contract;

(f) any policy or contract issued in this state by a member insurer at a time when it was not licensed or did not have a certificate of authority to issue the policy or contract in this state;

(g) any unallocated annuity contract issued to an employee benefit plan that is protected under the federal pension benefit guaranty corporation; and

(h) any portion of any unallocated annuity contract that is not issued to or in connection with a specific employee, union, or association of natural persons benefit plan or a government lottery.

(7) This part must be liberally construed to effect the purpose under subsections (2) and (3), which constitute an aid and guide to interpretation.

(8) This part may not be construed to reduce the liability for unpaid assessments of the insureds of an impaired insurer operating under a plan with assessment liability."

Section 39. Section 33-10-202, MCA, is amended to read:

"33-10-202. Definitions. As used in this part, the following definitions apply:

1 (1) "Account" means any of the three accounts created under 33-10-203.

2 (2) "Association" means the Montana life and health insurance guaranty association created under
3 33-10-203.

4 (3) "Contractual obligation" means any obligation under covered policies.

5 (4) "Covered policy" means any policy or contract within the scope of this part under subsections
6 (4) through (6) of 33-10-201.

7 (5) "Impaired insurer" means:

8 (a) an insurer which after July 1, 1974, becomes insolvent and is placed under a final order of
9 liquidation, rehabilitation, or supervision by a court of competent jurisdiction; or

10 (b) an insurer considered by the commissioner after July 1, 1974, to be unable or potentially unable
11 to fulfill its contractual obligations.

12 (6) (a) "Member insurer" means any person authorized to transact in this state any kind of
13 insurance to which this part applies under subsections (4) and (6) of 33-10-201 insurer that is licensed or
14 that holds a certificate of authority to transact any kind of insurance in this state for which coverage is
15 provided under 33-2-201 and includes any insurer whose license or certificate of authority may have been
16 suspended, revoked, not renewed, or voluntarily withdrawn.

17 (b) The term does not include:

18 (i) a health service corporation;

19 (ii) a health maintenance organization;

20 (iii) a fraternal benefit society;

21 (iv) a mandatory state pooling plan;

22 (v) a mutual assessment company or any entity that operates on an assessment basis;

23 (vi) an insurance exchange; or

24 (vii) an entity similar to any of the entities listed in subsections (6)(b)(i) through (6)(b)(vi).

25 (7) "Person" means any individual, corporation, partnership, association, or voluntary organization.

26 (8) "Premiums" means direct gross insurance premiums and annuity considerations written on
27 covered policies, less return premiums and considerations on premiums and dividends paid or credited to
28 policyholders on the direct business. "Premiums" do not include premiums and considerations on contracts
29 between insurers and reinsurers. As used in 33-10-227, "premiums" are those for the calendar year
30 preceding the determination of impairment.

(9) "Resident" means any person who resides in this state at the time the impairment is determined and to whom contractual obligations are owed.

(10) "Unallocated annuity contract" means an annuity contract or group annuity certificate that is not issued to and owned by an individual, except to the extent of annuity benefits guaranteed to an individual by the insurer under the contract or certificate."

Section 40. Section 33-11-102, MCA, is amended to read:

"33-11-102. Definitions. As used in this part, the following definitions apply:

(1) "Completed operations liability" means:

(a) liability arising out of the installation, maintenance, or repair of any product at a site that is not owned or controlled by:

(i) a person who performs that work; or

(ii) a person who hires an independent contractor to perform that work; and

(b) liability for activities that are completed or abandoned before the date of the occurrence giving rise to the liability.

(2) "Domicile", for purposes of determining the state where a purchasing group is domiciled, means:

(a) for a corporation, the state where the purchasing group is incorporated; and

(b) for an unincorporated entity, the state of its principal place of business.

~~(2)~~(3) "Hazardous financial condition" means that, based on its present or reasonably anticipated financial condition, a risk retention group, although not yet financially impaired or insolvent, is unlikely to be able to:

(a) meet obligations to policyholders with respect to known claims and reasonably anticipated claims; or

(b) pay other obligations in the normal course of business.

~~(3)~~(4) "Insurance" means primary insurance, excess insurance, reinsurance, surplus line insurance, and any other arrangement for shifting and distributing risk that is determined to be insurance under the laws of this state.

~~(4)~~(5) (a) "Liability" means legal liability for damages, including costs of defense, legal costs and fees, and other claims expenses, because of injuries to other persons, damage to their property, or other

1 damage or loss to other persons resulting from or arising out of:

2 (i) a business, whether profit or nonprofit, trade, product, service (including professional service),
3 premises, or operation; or

4 (ii) an activity of any state or local government or an agency or political subdivision ~~thereof~~ of state
5 or local government.

6 (b) The term does not include personal risk liability or an employer's liability with respect to its
7 employees other than legal liability under the federal Employers' Liability Act, ~~{45 U.S.C. 51 through 60}~~.

8 As used in this subsection, "personal risk liability" means liability for damages because of injury to any
9 person, damage to property, or other loss or damage resulting from personal, familial, or household
10 responsibilities or activities rather than from responsibilities or activities referred to in subsection ~~(4)(a)~~
11 (5)(a).

12 ~~(5)(6)~~ "Plan of operation or a feasibility study" means an analysis that presents the expected
13 activities and results of a risk retention group, including at a minimum:

14 (a) the coverages, deductibles, coverage limits, rates, and rating classification systems for each
15 line of insurance the group intends to offer;

16 (b) historical and expected loss experience of the proposed members and national experience of
17 similar exposures to the extent this experience is reasonably available;

18 (c) pro forma financial statements and projections;

19 (d) appropriate opinions by a qualified independent casualty actuary, including a determination of
20 minimum premium or participation levels required to commence operations and to prevent a hazardous
21 financial condition;

22 (e) identification of management, underwriting procedures, managerial oversight methods, and
23 investment policies; and

24 (f) other matters as may be prescribed by the commissioner for liability insurance companies
25 authorized by the insurance laws of the state where the risk retention group is chartered.

26 ~~(6)(7)~~ "Purchasing group" means a group that:

27 (a) has as one of its purposes the purchase of liability insurance on a group basis;

28 (b) purchases liability insurance only for its group members and only to cover their similar or related
29 liability exposure, as described in subsection ~~(6)(c)~~ (7)(c);

30 (c) is composed of members whose businesses or activities are similar or related with respect to

1 the liability to which members are exposed by virtue of any related, similar, or common business, trade,
2 product, service, premises, or operation; and

3 (d) is domiciled in any state.

4 ~~(7)~~(8) "Risk retention group" means a corporation or other limited liability association formed under
5 the laws of any state, Bermuda, or the Cayman Islands:

6 (a) whose primary activity consists of assuming and spreading all or any portion of the liability
7 exposure of its group members;

8 (b) that is organized for the primary purpose of conducting the activity described under subsection
9 ~~(7)(a)~~ (8)(a);

10 (c) (i) that is chartered and licensed as a liability insurance company and authorized to engage in
11 the business of insurance under the laws of any state; or

12 (ii) that, before January 1, 1985, was chartered or licensed and authorized to engage in the
13 business of insurance under the laws of Bermuda or the Cayman Islands and, before that date, had certified
14 to the insurance regulatory official of at least one state that it satisfied the capitalization requirements of
15 that state. However, ~~such~~ the group is considered to be a risk retention group only if it has been engaged
16 in business continuously since January 1, 1985, and only for the purpose of continuing to provide
17 insurance to cover product liability or completed operations liability.

18 ~~(A) For purposes of this subsection (7), "completed operations liability" means liability arising out~~
19 ~~of the installation, maintenance, or repair of any product at a site which is not owned or controlled by a~~
20 ~~person who performs that work or hires an independent contractor to perform that work and includes~~
21 ~~liability for activities which are completed or abandoned before the date of the occurrence giving rise to the~~
22 ~~liability.~~

23 ~~(B)~~ For purposes of this subsection ~~(7)~~ (8), "product liability" means liability for damages because
24 of any personal injury, death, emotional harm, consequential economic damage, or property damage,
25 ~~(including damages resulting from the loss of use of property),~~ arising out of the manufacture, design,
26 importation, distribution, packaging, labeling, lease, or sale of a product but does not include the liability
27 of any person for those damages if the product involved was in the possession of that person when the
28 incident giving rise to the claim occurred.

29 (d) that does not exclude any person from membership in the group solely to provide to members
30 of the group a competitive advantage over ~~such~~ the person;

1 (e) (i) that has as its members only persons who have an ownership interest in the group and that
2 has as its owners only persons who are members and who are provided insurance by the risk retention
3 group; or

4 (ii) that has as its sole member and sole owner an organization that is owned by persons who are
5 provided insurance by the risk retention group;

6 (f) whose members are engaged in businesses or activities that are similar or related with respect
7 to the liability to which the members are exposed by virtue of any related, similar, or common business,
8 trade, product, service, premises, or operation;

9 (g) whose activities do not include the provision of insurance other than:

10 (i) liability insurance for assuming and spreading all or any portion of the liability of its group
11 members; and

12 (ii) reinsurance with respect to the liability of any other risk retention group or member of ~~such~~ the
13 other group that is engaged in businesses or activities so that ~~such~~ the group or member meets the
14 requirement described in subsection ~~(7)(f)~~ (8)(f) for membership in the risk retention group that provides
15 the reinsurance; and

16 (h) whose name includes the phrase "risk retention group".

17 ~~(8)(9)~~ "State" means any state of the United States or the District of Columbia."

18
19 **Section 41.** Section 33-11-104, MCA, is amended to read:

20 **"33-11-104. Risk retention groups not chartered in this state.** A risk retention group chartered in
21 a state other than this state and seeking to do business as a risk retention group in this state must observe
22 and abide by the laws of this state as follows:

23 (1) Before offering insurance in this state, a risk retention group shall submit to the commissioner:

24 (a) a statement identifying the state or states where the risk retention group is chartered and
25 authorized as a casualty insurer, date of chartering, its principal place of business, and other information,
26 including information on its membership, as the commissioner requires to verify that the risk retention group
27 is qualified under 33-11-102~~(7)~~(8);

28 (b) a copy of its plan of operation or a feasibility study and revisions of the plan or study submitted
29 to its state of domicile. However, this provision relating to the submission of a plan of operation or a
30 feasibility study does not apply with respect to any line or classification of liability insurance that was

1 defined in the federal Product Liability Risk Retention Act of 1981 (15 U.S.C. 3901 through 3904) before
2 it was amended by P.L. 99-563, approved on October 27, 1986, and that was offered before that date by
3 a risk retention group that had been chartered and operated for not less than 3 years before that date; and

4 (c) a statement of registration that designates the commissioner as its agent for the purpose of
5 receiving service of legal documents or process.

6 (2) A risk retention group doing business in this state shall submit to the commissioner:

7 (a) a copy of the group's financial statement submitted to its state of domicile, which must be
8 certified by an independent public accountant and contain a statement of opinion on loss and loss
9 adjustment expense reserves made by a member of the American academy of actuaries or by a qualified
10 loss reserve specialist under criteria established by the national association of insurance commissioners;

11 (b) a copy of each examination of the risk retention group as certified by the insurance regulatory
12 official of the state in which the examination was conducted or public official conducting the examination;

13 (c) upon request by the commissioner, a copy of any audit performed with respect to the risk
14 retention group; and

15 (d) any information as may be required to verify the group's continuing qualification as a risk
16 retention group under 33-11-102~~(7)~~(8).

17 (3) (a) Each risk retention group is liable for the payment of premium taxes and taxes on premiums
18 of direct business for risks resident or located within this state and shall report to the commissioner the net
19 premiums written for risks resident or located within this state. The risk retention group is subject to
20 taxation and any applicable interest, fines, and penalties for nonpayment that apply to foreign admitted
21 insurers.

22 (b) To the extent that an insurance producer is used, the insurance producer shall report to the
23 commissioner the premiums of direct business for risks resident or located within this state that the
24 licensees have placed with or on behalf of a risk retention group not chartered in this state.

25 (c) To the extent that an insurance producer is used, the insurance producer shall keep a complete
26 and separate record of all policies procured from each risk retention group. The record is open to
27 examination by the commissioner, as provided in 33-1-408. The records must, for each policy and each
28 kind of insurance provided under the policy, include the limit of liability, the time period covered, the
29 effective date, the name of the risk retention group that issued the policy, the gross premium charged, and
30 the amount of return premiums, if any.

1 (4) Each risk retention group, its insurance producers, and its representatives shall comply with
2 Title 33, chapter 18, part 2.

3 (5) Each risk retention group shall comply with the provisions of Title 33, chapter 18, part 2,
4 regarding deceptive, false, or fraudulent acts or practices. However, if the commissioner seeks an injunction
5 regarding the risk retention group's conduct, the injunction must be obtained from a court of competent
6 jurisdiction.

7 (6) Each risk retention group shall submit to an examination by the commissioner to determine its
8 financial condition if the insurance regulatory official of the jurisdiction where the group is chartered has
9 not initiated an examination or does not initiate an examination within 60 days after a request by the
10 commissioner. The examination must be coordinated to avoid unjustified repetition and be conducted in an
11 expeditious manner in accordance with the national association of insurance commissioners examiners
12 handbook.

13 (7) Each policy issued by a risk retention group must contain, in 10-point type on the front page
14 and the declaration page, the following notice:

15 "NOTICE

16 This policy is issued by your risk retention group. Your risk retention group may not be subject to
17 all of the insurance laws and regulations of your state. State insurance insolvency guaranty funds are not
18 available for your risk retention group."

19 (8) The following acts by a risk retention group are prohibited:

20 (a) the solicitation or sale of insurance by a risk retention group to any person who is not eligible
21 for membership in the group; and

22 (b) the solicitation or sale of insurance by or operation of a risk retention group that is in a
23 hazardous financial condition or is financially impaired.

24 (9) A risk retention group is not allowed to do business in this state if an insurer is directly or
25 indirectly a member or owner of the risk retention group, other than in the case of a risk retention group
26 all of whose members are insurers.

27 (10) A risk retention group may not offer insurance policy coverage declared unlawful by the
28 Montana supreme court.

29 (11) A risk retention group not chartered in this state and doing business in this state shall comply
30 with a lawful order issued in a voluntary dissolution proceeding or in a delinquency proceeding commenced

1 by the insurance regulatory official of any state if there has been a finding of financial impairment after an
2 examination under subsection (6).

3 (12) Upon completion of registration requirements, the commissioner shall issue to the risk retention
4 group a proper certificate of registration.

5 (13) A risk retention group that violates any provision of this chapter is subject to fines and
6 penalties, including revocation of the right to do business in this state, applicable to licensed insurers
7 generally."

8
9 **Section 42.** Section 33-11-108, MCA, is amended to read:

10 **"33-11-108. Notice and registration requirements of purchasing groups.** (1) A purchasing group
11 that intends to do business in this state shall furnish notice to the commissioner that:

12 (a) identifies the state where the group is domiciled and all other states in which the group intends
13 to do business;

14 (b) specifies the lines and classifications of liability insurance that the purchasing group intends to
15 purchase;

16 (c) identifies the insurer from which the purchasing group intends to purchase its insurance and
17 the domicile of ~~the~~ that insurer;

18 (d) identifies the Montana-licensed insurance producer or Montana-licensed surplus lines insurance
19 producer through which the purchasing group intends to place its business;

20 (e) identifies the principal place of business of the purchasing group; ~~and~~

21 (f) provides information required by the commissioner to verify that the purchasing group is
22 qualified under 33-11-102~~(6)~~(7); and

23 (g) identifies the person or persons controlling the activities of the group and includes biographical
24 information on the person or persons.

25 (2) The purchasing group shall register with and designate the commissioner as its agent solely for
26 the purpose of receiving service of legal documents or process. However, the requirements do not apply
27 in the case of a purchasing group:

28 (a) (i) that was domiciled before April 2, 1986, in any state of the United States; and

29 (ii) that was domiciled on and after October 27, 1986, in any state of the United States;

30 (b) (i) that, before October 27, 1986, purchased insurance from an insurer licensed in any state;

1 and

2 (ii) that, since October 27, 1986, purchased its insurance from an insurer licensed in any state;

3 (c) that was a purchasing group under the requirements of the federal Product Liability Risk
4 Retention Act of 1981 (15 U.S.C. 3901 through 3904) before it was amended by P.L. 99-563, approved
5 on October 27, 1986; and

6 (d) that does not purchase insurance that was not authorized for purposes of an exemption under
7 the federal Product Liability Risk Retention Act of 1981, as in effect before October 27, 1986.

8 (3) Upon completion of registration requirements, the commissioner shall issue a proper certificate
9 of registration to the purchasing group."

10
11 **Section 43.** Section 33-14-304, MCA, is amended to read:

12 **"33-14-304. Cancellation of insurance upon default.** (1) When a premium finance agreement

13 contains a power of attorney or other authority enabling the insurance premium finance company to cancel
14 any insurance contract listed in the agreement, the insurance contract or contracts may not be canceled
15 by the premium finance company unless ~~such~~ the cancellation is effectuated in accordance with this
16 section.

17 (2) ~~Not less than 10 days' written~~ Written notice must be mailed to the insured setting forth the
18 intent of the insurance premium finance company to cancel the insurance contract unless the default is
19 cured prior to the date stated in the notice. The written notice must be mailed at least 10 days prior to the
20 date stated in the notice. The insurance producer ~~or broker~~ indicated on the premium finance agreement
21 ~~shall~~ must also be mailed 10 days' notice of this action.

22 (3) Pursuant to the power of attorney or other authority referred to above, the insurance premium
23 finance company may cancel on behalf of the insured by mailing to the insurer written notice stating when
24 ~~thereafter~~ the cancellation ~~shall be~~ will become effective, and the insurance contract ~~shall~~ must be canceled
25 as if ~~such~~ the notice of cancellation had been submitted by the insured ~~himself~~ but without requiring the
26 return of the insurance contract. If the insurer or its insurance producer does not provide the insurance
27 premium finance company with a specific mailing address for the purpose of receipt of the ~~above~~ notice,
28 mailing by the insurance premium finance company to the insurer at the address that is on file ~~and of record~~
29 with the commissioner is considered sufficient notice under this section. The insurance premium finance
30 company shall also mail a notice of cancellation to the insured at ~~his~~ the insured's last-known address and

1 to the insurance producer ~~or broker~~ indicated on the premium finance agreement.

2 (4) All statutory, regulatory, and contractual restrictions providing that the insurance contract may
3 not be canceled unless notice is given to a governmental agency, mortgagee, or other third party apply
4 whenever cancellation is effected under the provisions of this section. The insurer shall give the prescribed
5 notice in behalf of itself or the insured to any governmental agency, mortgagee, or other third party on or
6 before the second business day after the day it receives the notice of cancellation from the premium finance
7 company and shall determine the effective date of cancellation taking into consideration the number of
8 days' notice required to complete the cancellation."

9

10 **Section 44.** Section 33-15-301, MCA, is amended to read:

11 **"33-15-301. Requiring standard provisions -- waiver.** (1) Insurance contracts ~~shall~~ must contain
12 ~~such the~~ the standard or uniform provisions ~~as are~~ and benefits required by the applicable provisions of this
13 code pertaining to contracts of particular kinds of insurance. The commissioner may waive ~~the required use~~
14 ~~of~~ a particular provision in a particular insurance policy form if:

15 (a) ~~he the commissioner~~ finds ~~such the~~ the provision or benefit unnecessary for the protection of the
16 insured and inconsistent with the purposes of the policy; and

17 (b) the policy is otherwise approved by ~~him~~ the commissioner.

18 (2) ~~No A~~ A policy or certificate ~~shall~~ may not contain any provision or benefit inconsistent with or
19 contradictory to any standard or uniform provision or benefit used or required to be used, but the
20 commissioner may approve any substitute provision or benefit ~~which~~ that is, in ~~his~~ the commissioner's
21 opinion, not less favorable in any particular to the insured or beneficiary than the provisions otherwise
22 required.

23 (3) In lieu of the provisions required by this code for contracts for particular kinds of insurance,
24 substantially similar provisions required by the law of the domicile of a foreign or alien insurer may be used
25 when approved by the commissioner.

26 (4) ~~No such A~~ A provision, if required to be contained in the policy, ~~can~~ may not be waived by
27 agreement between the insurer and any other person."

28

29 **Section 45.** Section 33-15-303, MCA, is amended to read:

30 **"33-15-303. Contents of policies in general -- identification.** (1) ~~Every~~ Each policy shall must

1 specify:

- 2 (a) the names of the parties to the contract;
- 3 (b) the subject of the insurance;
- 4 (c) the risks insured against;
- 5 (d) the time when the insurance under the policy takes effect and the period during which the
- 6 insurance is to continue;
- 7 (e) the premium;
- 8 (f) the conditions pertaining to the insurance.

9 (2) If under the policy the exact amount of premium is determinable only at stated intervals or
 10 termination of the contract, a statement of the basis and rates upon which the premium is to be determined
 11 and paid must be included.

12 (3) All policies and annuity contracts issued by insurers and the forms of policies and annuity
 13 contracts filed with the commissioner must have printed on the policy or annuity contract an appropriate
 14 designating letter or figure, combination of letters or figures, or terms identifying the respective forms of
 15 policies or contracts, ~~together with the year of adoption of the form.~~ Each form, including riders and
 16 endorsements, must be identified by a designating letter or figure placed in a lower, preferably left-hand,
 17 corner of the first page of the form. Whenever any change is made in any form, the designating letters,
 18 figures, or terms ~~and year of adoption~~ on the form must be correspondingly changed and the revision date
 19 must be noted next to the designating letters."

21 **Section 46.** Section 33-16-202, MCA, is amended to read:

22 **"33-16-202. Recording and reporting of loss and expense experience.** (1) The commissioner ~~shall~~
 23 may promulgate and may modify reasonable rules and statistical plans, reasonably adapted to each of the
 24 rating systems used, ~~and which shall~~ must thereafter be used by each insurer in the recording and reporting
 25 of its loss and countrywide expense experience, in order that the experience of all insurers may be made
 26 available at least annually in ~~such~~ form and detail as ~~may be~~ necessary to aid ~~him~~ the commissioner in
 27 determining whether rates comply with the applicable standards of this chapter. ~~Such~~ The rules and plans
 28 may also provide for the recording and reporting of expense experience items ~~which~~ that are specially
 29 applicable to this state and are not susceptible of determination by a prorating of countrywide expense
 30 experience.

1 (2) In promulgating ~~such~~ rules and plans, the commissioner shall give ~~due~~ consideration to the
2 rating systems in use in this state and, in order that ~~such~~ the rules and plans may be as uniform as is
3 practicable among the several states, to the rules and to the form of the plans used for ~~such~~ rating systems
4 in other states. ~~No~~ An insurer ~~shall~~ may not be required to record or report its loss experience on a
5 classification basis that is inconsistent with the rating system used by it.

6 (3) The commissioner may designate one or more rating organizations or other agencies to assist
7 him in gathering ~~such~~ and making compilations of loss and expense experience ~~and making compilations~~
8 ~~thereof~~, and ~~such~~ the compilations ~~shall~~ must be made available, subject to reasonable rules promulgated
9 by the commissioner, to insurers and rating organizations."

10

11 **Section 47.** Section 33-16-235, MCA, is amended to read:

12 **"33-16-235. Data reporting -- rules.** (1) An insurer that has transacted a line of insurance
13 designated as noncompetitive or volatile ~~shall~~ may report once a year to the commissioner, on forms
14 prescribed by the commissioner, information including:

- 15 (a) reported and estimated ultimate exposure, by year of exposure to loss;
16 (b) reported and estimated ultimate premiums, by year of exposure to loss;
17 (c) losses paid, by year incurred;
18 (d) loss adjustment expense paid, by year incurred;
19 (e) reported and ultimately incurred losses and loss adjustment expenses, by year incurred; and
20 (f) any other information required by the commissioner.

21 (2) An insurer transacting a line of insurance designated as noncompetitive or volatile shall provide
22 to the commissioner information concerning at least 5 years of experience, with information evaluated as
23 of the end of each calendar year. In addition to the latest reported information for each year, the insurer
24 shall document any adjustments, including but not limited to development factors and trend adjustments,
25 made to the reported data in projecting losses.

26 (3) The commissioner ~~shall~~ may adopt by rule reasonable development factors and trend
27 adjustments to be applied to the reported data."

28

29 **Section 48.** Section 33-17-102, MCA, is amended to read:

30 **"33-17-102. Definitions.** As used in this title, the following definitions apply:

1 (1) "Adjuster" means a person who, on behalf of the insurer, for compensation as an independent
2 contractor or as the employee of an independent contractor or for fee or commission investigates and
3 negotiates settlement of claims arising under insurance contracts or otherwise acts on behalf of the insurer.

4 The term does not include a:

5 (a) licensed attorney who is qualified to practice law in this state;

6 (b) salaried employee of an insurer or of a managing general agent; ~~or~~

7 (c) licensed insurance producer who adjusts or assists in adjustment of losses arising under policies
8 issued by the insurer; or

9 (d) licensed third-party administrator who adjusts or assists in adjustment of losses arising under
10 policies issued by the insurer.

11 (2) "Adjuster license" means a document issued by the commissioner that authorizes a person to
12 act as an adjuster.

13 (3) (a) "Administrator" means a person who collects charges or premiums from residents of this
14 state in connection with life, disability, property, or casualty insurance or annuities or who adjusts or settles
15 claims on ~~such coverage~~ these coverages.

16 (b) The term does not mean:

17 (i) an employer on behalf of its employees or on behalf of the employees of one or more
18 subsidiaries of affiliated corporations of the employer;

19 (ii) a union on behalf of its members;

20 (iii) (A) an insurer that is either authorized in this state or acting as an insurer with respect to a
21 policy lawfully issued and delivered by it in and pursuant to the laws of a state in which the insurer is
22 authorized to transact insurance; or

23 (B) a health service corporation as defined in 33-30-101;

24 (iv) a life, disability, property, or casualty insurance producer who is licensed in this state and
25 whose activities are limited exclusively to the sale of insurance;

26 (v) a creditor on behalf of its debtors with respect to insurance covering a debt between the
27 creditor and its debtors;

28 (vi) a trust established in conformity with 29 U.S.C. 186 or the trustees, agents, and employees
29 of the trust;

30 (vii) a trust exempt from taxation under section 501(a) of the Internal Revenue Code or the trustees

1 and employees of the trust;

2 (viii) a custodian acting pursuant to a custodian account that meets the requirements of section
3 401(f) of the Internal Revenue Code or the agents and employees of the custodian;

4 (ix) a bank, credit union, or other financial institution that is subject to supervision or examination
5 by federal or state banking authorities;

6 (x) a company that issues credit cards and that advances for and collects premiums or charges
7 from its credit card holders who have authorized it to do so, if the company does not adjust or settle claims;
8 or

9 (xi) a person who adjusts or settles claims in the normal course of ~~his~~ the person's practice or
10 employment as an attorney and who does not collect charges or premiums in connection with life or
11 disability insurance or annuities.

12 (4) "Administrator license" means a document issued by the commissioner that authorizes a person
13 to act as an administrator.

14 (5) "Consultant" means a person who for a fee examines, appraises, reviews, or evaluates an
15 insurance policy, annuity, or pension contract, plan, or program or who makes recommendations or gives
16 advice on an insurance policy, annuity, or pension contract, plan, or program.

17 (6) "Consultant license" means a document issued by the commissioner that authorizes a person
18 to act as an insurance consultant.

19 (7) "Controlled business" means insurance procured or to be procured by or through a person upon
20 the life, person, property, or risks of ~~himself~~ the person, his or the person's spouse, ~~his~~ employer, or ~~his~~
21 business.

22 (8) "Individual" means a private or natural person, as distinguished from a partnership, corporation,
23 or association.

24 (9) "Insurance producer", except as provided in 33-17-103:

25 (a) means:

26 (i) a person who solicits, negotiates, effects, procures, delivers, renews, continues, or binds:

27 (A) policies of insurance for risks residing, located, or to be performed in this state; or

28 (B) membership contracts as defined in 33-30-101;

29 (ii) a managing general agent. For purposes of this ~~definition, a chapter, the term~~ "managing general
30 agent" ~~is a person who, on behalf of an insurer, exercises general supervision over the business of the~~

~~insurer in this state or in any other state, including the authority to contract with an insurance producer for the insurer and terminate those contracts~~ has the same meaning as set forth in 33-2-1501.

(b) does not mean a customer service representative. For purposes of this definition, a "customer service representative" means a salaried employee of an insurance producer who assists and is responsible to the insurance producer.

(10) "License" means a document issued by the commissioner that authorizes a person to act as an insurance producer for the kinds of insurance specified in the document. The license itself does not create actual, apparent, or inherent authority in the holder to represent or commit an insurer to a binding agreement.

(11) "Person" means an individual, partnership, corporation, association, or other legal entity.

(12) "Public adjuster" means an adjuster employed by and representing the interests of the insured."

Section 49. Section 33-17-211, MCA, is amended to read:

"33-17-211. General qualifications -- application for license. (1) An individual applying for a license shall apply on a form specified by the commissioner and declare under penalty of refusal, suspension, or revocation of the license that statements made in the application are true, correct, and complete to the best of the individual's knowledge and belief. Before approving the application, the commissioner shall verify that the individual:

(a) is 18 years of age or older;

(b) has not committed an act that is a ground for refusal, suspension, or revocation as set forth in 33-17-1001;

(c) has paid the license fees stated in 33-2-708;

(d) has successfully passed the examinations for each kind of insurance for which the individual has applied within 12 months of application;

(e) is a resident of this state or of another state that grants similar privileges to residents of this state. Licenses issued based upon Montana state residency terminate if the licensee relocates to another state;

(f) is competent, trustworthy, and of good reputation;

(g) has experience or training or otherwise is qualified in the kind or kinds of insurance for which ~~he~~ the applicant applies to be licensed and is reasonably familiar with the provisions of this code which

1 govern ~~his~~ the applicant's operations as an insurance producer; and

2 (h) if applying for a license as to life or disability insurance:

3 (i) is not a funeral director, undertaker, or mortician operating in this or any other state;

4 (ii) is not an officer, employee, or representative of a funeral director, undertaker, or mortician
5 operating in this or any other state; or

6 (iii) does not hold an interest in or benefit from a business of a funeral director, undertaker, or
7 mortician operating in this or any other state.

8 (2) A person acting as an insurance producer shall obtain a license. A person shall apply for a
9 license on a form specified by the commissioner. Before approving the application, the commissioner shall
10 verify that:

11 (a) the person meets the requirements listed in subsection (1);

12 (b) the person has paid the licensing fees stated in 33-2-708 for each individual licensed in
13 conjunction with the person's license. A licensed person shall promptly notify the commissioner of each
14 change relating to an individual listed in the license.

15 (c) the person has designated a licensed officer responsible for compliance by the person with the
16 insurance laws and rules of this state;

17 (d) each member and employee of a partnership and each officer, director, stockholder, or
18 employee of a corporation who is acting as an insurance producer in this state has obtained a license;

19 (e) (i) if the person is a partnership or corporation, the transaction of insurance business is within
20 the purposes stated in the partnership agreement or the articles of incorporation; and

21 (ii) if the person is a corporation, the secretary of state has issued a certificate of existence or
22 authorization under 35-1-1312 or filed articles of incorporation under ~~35-2-214~~ 35-1-220.

23 (3) The commissioner may license as a resident insurance producer an association of licensed
24 Montana insurance producers, whether or not incorporated, formed and existing substantially for purposes
25 other than insurance. The license must be used solely for the purpose of enabling the association to place,
26 as a resident insurance producer, insurance of the properties, interests, and risks of the state of Montana
27 and of other public agencies, bodies, and institutions and to receive the customary commission for the
28 placement. The president and secretary of the association shall apply for the license in the name of the
29 association, and the commissioner shall issue the license to the association in its name alone. The fee for
30 the license is the same as that required by 33-2-708 for the license of an insurance producer. The

1 commissioner may, after a hearing with notice to the association, revoke the license if ~~he~~ the commissioner
2 finds that continuation of the license is not in the public interest or that a ground listed in 33-17-1001
3 exists.

4 (4) An insurance producer using an assumed business name shall register the name with the
5 commissioner before using it."

6
7 **Section 50.** Section 33-17-405, MCA, is amended to read:

8 **"33-17-405. Service of process -- commissioner as agent.** ~~A nonresident person shall file with the~~
9 ~~commissioner the required forms appointing the~~ The commissioner and his successors in office shall act
10 ~~as the a~~ as a nonresident person's agent upon whom process in a legal proceeding against the nonresident
11 person may be served, ~~and shall agree that such~~ Service of process on the commissioner process has ~~has~~
12 the same legal force and validity as personal service of process upon the nonresident person. The
13 commissioner shall, within 3 working days after receiving process, forward by certified mail, at to the
14 nonresident person's address of record, a copy of the process ~~by certified mail to the person for whom he~~
15 ~~has received the process."~~

16
17 **Section 51.** Section 33-17-503, MCA, is amended to read:

18 **"33-17-503. Application -- fee -- expiration.** (1) Before a consultant license is issued or renewed,
19 the prospective licensee shall:

20 (a) properly file in the office of the commissioner a written application on forms the commissioner
21 prescribes; and

22 (b) pay a fee of \$50, which the commissioner shall deposit with the state treasurer to be credited
23 to the state's general fund.

24 (2) Each consultant license ~~expires on May 31 next following the date of issue~~ must be renewed
25 each year by the consultant paying a continuation fee on or before May 31, and the license continues in
26 force unless suspended, revoked, or otherwise terminated."

27
28 **Section 52.** Section 33-17-603, MCA, is amended to read:

29 **"33-17-603. Certificate of registration.** (1) Except as provided in 33-17-604, a person may not
30 act as or ~~hold himself out to be~~ represent to the public that the person is an administrator in this state

1 unless ~~he~~ the person holds a certificate of registration as an administrator.

2 (2) An application for a certificate of registration must be accompanied by a fee of \$100. The
3 commissioner shall issue the certificate unless ~~he~~ the commissioner finds that the applicant is not
4 competent, trustworthy, financially responsible, or of good personal and business reputation or that the
5 applicant has had a previous application for a license denied for cause within 5 years.

6 (3) ~~The A certificate of registration is renewable annually on July 1. A request for renewal must~~
7 ~~be accompanied by a renewal fee of \$100~~ must be renewed each year by the administrator paying a
8 continuation fee of \$100 on or before July 1. Upon payment, the license continues in force unless
9 suspended, revoked, or otherwise terminated. The commissioner shall deposit the fee with the state
10 treasurer to be credited to the general fund.

11 (4) ~~The A~~ certificate of registration may be suspended or revoked if, after notice and hearing, the
12 commissioner finds that the administrator has violated any of the requirements of this part or that the
13 administrator is not competent, trustworthy, financially responsible, or of good personal and business
14 reputation.

15 (5) Unless ~~the~~ a certification requirement is waived, a person who acts as an administrator without
16 a certificate of registration is subject to a fine of not less than \$500 or more than \$1,500."

17

18 **Section 53.** Section 33-17-1001, MCA, is amended to read:

19 **"33-17-1001. Suspension, revocation, or refusal of license.** (1) Except as provided in 33-17-411,
20 after a hearing, which must be held no less than 10 days after advance notice by certified mail, on charges
21 given under 33-1-314(3), the commissioner may suspend for up to 5 years, revoke, refuse to continue, or
22 deny a license issued under this chapter if the commissioner finds that the licensee or applicant has:

23 (a) engaged or is about to engage in an act or practice for which issuance of the license could have
24 been refused;

25 (b) obtained or attempted to obtain a license through misrepresentation or fraud;

26 (c) violated or failed to comply with a provision of this code or has violated a rule, subpoena, or
27 order of the commissioner or of the commissioner of any other state;

28 (d) improperly withheld, misappropriated, or converted to the licensee's or applicant's own use
29 money or property belonging to policyholders, insurers, beneficiaries, or others and received in conduct of
30 business under the license;

1 (e) been convicted of a felony;

2 (f) in the conduct of the affairs under the license, used fraudulent, coercive, or dishonest practices
3 or the licensee or applicant is incompetent, untrustworthy, financially irresponsible, or a source of injury
4 and loss to the public;

5 (g) made a materially untrue statement in the license application or in the continuing education
6 affidavit;

7 (h) misrepresented the terms of an actual or proposed insurance contract;

8 (i) been found guilty of an unfair trade practice or fraud prohibited by Title 33, chapter 18;

9 (j) had a similar license suspended or revoked in any other state;

10 (k) forged another's name to an application for insurance;

11 (l) cheated on an examination for a license; or

12 (m) knowingly accepted insurance business from a person who is not licensed.

13 (2) The license of a partnership or corporation may be suspended, revoked, refused, or denied if
14 a reason listed in subsection (1) applies to an individual designated in the license to exercise its powers or
15 to a partner or officer in the partnership or corporation.

16 (3) The commissioner may suspend, revoke, or refuse to continue a license under subsection (1)(e)
17 without conducting an investigation pursuant to 37-1-203 or making a written finding pursuant to
18 37-1-204."

19
20 **Section 54.** Section 33-18-212, MCA, is amended to read:

21 **"33-18-212. Illegal dealing in premiums -- improper charges for insurance.** (1) A person may not
22 willfully collect any sum as a premium or charge for insurance, ~~which insurance~~ that is not then provided
23 or is not in due course to be provided, ~~{subject to acceptance of the risk by the insurer},~~ by an insurance
24 policy issued by an insurer as authorized by this code.

25 (2) A person may not willfully collect as a premium or charge for insurance any sum in excess of
26 or less than the premium or charge applicable to ~~such~~ the insurance and, as specified in the policy, in
27 accordance with the applicable classifications and rates ~~as~~ and or approved by the commissioner;
28 or in cases ~~where~~ in which classifications, premiums, or rates are not required by this code to be ~~so~~ filed
29 ~~and or~~ approved, ~~such~~ the premiums and charges may not be in excess of or less than those specified in
30 the policy and as fixed by the insurer. This provision may not ~~be deemed to~~ prohibit the charging and

1 collection, by surplus lines insurance producers licensed under chapter 2, part 3, of the amount of
2 applicable state and federal taxes in addition to the premium required by the insurer. ~~‡~~ This provision may
3 ~~not be considered to~~ prohibit the charging and collection, by a life insurer, of amounts actually to be
4 expended for medical examination of an applicant for life insurance or for reinstatement of a life insurance
5 policy.

6 (3) Each violation of this section is punishable under 33-1-104."
7

8 **Section 55.** Section 33-18-301, MCA, is amended to read:

9 **"33-18-301. Prohibited relations with mortuaries.** (1) ~~No A~~ A life insurer and its officers, employees,
10 or representatives may not own, manage, supervise, operate, or maintain any mortuary, funeral, or
11 undertaking establishment or permit its officers, employees, or representatives to own, operate, maintain,
12 or be employed in any such business in Montana.

13 (2) ~~No A~~ A life insurer may not contract or agree with any funeral director, mortuary, or undertaker
14 to the effect that such the funeral director, undertaker, or mortuary shall conduct the funeral or be named
15 beneficiary of any person insured by such the insurer. This subsection does not prohibit a life insurer from
16 making insurance, designated as funeral insurance, available.

17 (3) A funeral insurance policy and any solicitation material for the policy must clearly indicate that:

18 (a) the policy is a life insurance product;

19 (b) the applicant may designate the beneficiary, provided that there is an appropriate and insurable
20 interest;

21 (c) the beneficiary may use the proceeds for any purpose; and

22 (d) any attempt by the insurer or its representative to have the insured designate a specific
23 beneficiary, including but not limited to a funeral director, mortuary, or undertaker, constitutes a violation
24 of this section punishable as a misdemeanor pursuant to subsection (4).

25 ~~(3)(4)~~ (4) Each violation of this section constitutes a misdemeanor punishable by a fine of not more
26 than \$1,000 or by imprisonment for not more than 6 months or ~~by both such fine and imprisonment.~~"
27

28 **Section 56.** Section 33-22-131, MCA, is amended to read:

29 **"33-22-131. Coverage for phenylketonuria treatment.** (1) Each group or individual medical
30 expense disability policy, certificate of insurance, and membership contract that is delivered, issued for

1 delivery, renewed, extended, or modified in this state must provide coverage for the treatment of
2 phenylketonuria.

3 (2) For purposes of this section, "treatment" means licensed professional medical services under
4 the supervision of a physician and a dietary formula product to achieve and maintain normalized blood levels
5 of phenylalanine and adequate nutritional status.

6 (3) These services are subject to the terms of the applicable group or individual disability policy,
7 certificate, or membership contract that establishes durational limits, dollar limits, deductibles, and
8 copayment provisions as long as the terms are not less favorable than for physical illness generally.

9 (4) This section does not apply to disability income, hospital indemnity, medicare supplement,
10 accident-only, vision, dental, or specified disease policies."

11
12 **Section 57.** Section 33-22-132, MCA, is amended to read:

13 **"33-22-132. Coverage for mammography examinations.** (1) Each group or individual medical
14 expense, cancer, hospital indemnity, and blanket disability policy, certificate of insurance, and membership
15 contract that is delivered, issued for delivery, renewed, extended, or modified in this state must provide
16 minimum mammography examination coverage.

17 (2) For the purpose of this section, "minimum mammography examination" means:

18 (a) one baseline mammogram for a woman who is 35 years of age or older and under 40 years of
19 age;

20 (b) a mammogram every 2 years for any woman who is 40 years of age or older and under 50
21 years of age or more frequently if recommended by the woman's physician; and

22 (c) a mammogram each year for a woman who is 50 years of age or older.

23 (3) A minimum \$70 payment or the actual charge if the charge is less than \$70 must be made for
24 each mammography examination performed before the application of the terms of the applicable group or
25 individual disability policy, certificate of insurance, or membership contract that establish durational limits,
26 deductibles, and copayment provisions as long as the terms are not less favorable than for physical illness
27 generally.

28 (4) This section does not apply to disability income, hospital indemnity, medicare supplement,
29 accident-only, vision, dental, or specified disease policies."

1 **Section 58.** Section 33-22-201, MCA, is amended to read:

2 **"33-22-201. Format and content.** A An individual policy of disability insurance may not be
3 delivered or issued for delivery to any person in this state unless it otherwise complies with this code and
4 complies with the following:

5 (1) The entire money and other considerations for the policy must be expressed in the policy.

6 (2) The time when the insurance takes effect and terminates must be expressed in the policy.

7 (3) The policy may insure only one person, except that a policy may insure, originally or by
8 subsequent amendment, upon the application of an adult member of a family who is the policyholder, any
9 two or more eligible members of that family, including husband, wife, dependent children or any children
10 under a specified age that may not exceed ~~19~~ 25 years, and any other person dependent upon the
11 policyholder.

12 (4) The style, arrangement, and overall appearance of the policy may not give undue prominence
13 to any portion of the text, and every printed portion of the text of the policy and of any endorsements or
14 attached papers must be plainly printed in lightfaced type of a style in general use, the size of which must
15 be uniform and not less than 10 point with a lowercase, unspaced alphabet length not less than 120 point.

16 (5) The "text" must include all printed matter except the name and address of the insurer, name
17 or title of the policy, the brief description, if any, and captions and subcaptions.

18 (6) The exceptions and reductions of indemnity must be set forth in the policy and, other than
19 those contained in 33-22-204 through 33-22-215 and ~~33-22-217~~ 33-22-221 through 33-22-231, must be
20 printed, at the insurer's option, either included with the benefit provision to which they apply or under an
21 appropriate caption such as "Exceptions" or "Exceptions and Reductions", except that if an exception or
22 reduction specifically applies only to a particular benefit of the policy, a statement of the exception or
23 reduction must be included with the benefit provision to which it applies.

24 ~~(7) Each form, including riders and endorsements, must be identified by a form number in the lower~~
25 ~~left hand corner of the first page of the form.~~

26 ~~(8)~~ (7) The policy may not contain a provision purporting to make any portion of the charter, rules,
27 constitution, or bylaws of the insurer a part of the policy unless the portion is set forth in full in the policy,
28 except in the case of the incorporation of or reference to a statement of rates or classification of risks or
29 short-rate table filed with the commissioner.

30 ~~(9) Each individual disability policy, except for a single premium nonrenewable policy, issued for~~

1 ~~delivery in this state on or after January 1, 1980, must contain a notice stating in substance that if the~~
2 ~~person to whom the policy is issued is not satisfied for any reason, the person is permitted to return the~~
3 ~~policy within 10 days of its delivery, or a longer period as the policy may provide, and to have refunded~~
4 ~~the amount of the premium paid. A policy returned pursuant to this subsection is void from the beginning."~~

5
6 **Section 59.** Section 33-22-202, MCA, is amended to read:

7 **"33-22-202. Required provisions -- captions -- omissions -- substitutions -- order.** (1) Except as
8 provided in subsection (2), each policy delivered or issued for delivery to any person in this state must
9 contain the provisions specified in 33-22-204 through 33-22-215, ~~in the words in which the~~ as those
10 provisions appear, except that the insurer may, at its option, substitute for one or more of the provisions
11 corresponding provisions of different wording approved by the commissioner ~~which are in each instance~~
12 and not less favorable in any respect to the insured or the beneficiary. Each provision must be preceded
13 ~~individually~~ by the applicable caption shown or, at the option of the insurer, by the appropriate individual
14 or group captions or subcaptions as the commissioner may approve.

15 (2) If any provision is in whole or in part inapplicable to or inconsistent with the coverage provided
16 by a particular form of policy, the insurer, with the approval of the commissioner, shall omit from the policy
17 any inapplicable provision or part of a provision and shall modify any inconsistent provision or part of a
18 provision in a manner as to make the provision as contained in the policy consistent with the coverage
19 provided by the policy.

20 (3) The provisions that are the subject of 33-22-204 through 33-22-215 and ~~33-22-217~~ 33-22-221
21 through 33-22-232 or any corresponding provisions which are used in accordance with the cited sections
22 must be printed in the consecutive order of the provisions in the sections or, at the option of the insurer,
23 any provision may appear as a unit in any part of the policy with other provisions to which it may be
24 logically related, provided that the resulting policy is not in whole or in part unintelligible, uncertain,
25 ambiguous, abstruse, or likely to mislead a person to whom the policy is offered, delivered, or issued."

26
27 **Section 60.** Section 33-22-301, MCA, is amended to read:

28 **"33-22-301. Coverage of newborn under disability policy.** (1) Each policy of disability insurance
29 or certificate issued ~~thereunder shall~~ must contain a provision granting immediate accident and sickness
30 coverage, from and after the moment of birth, to each newborn infant of any insured.

1 (2) The coverage for newborn infants must be the same as provided by the policy for the other
2 covered persons; ~~provided, however~~ However, that for newborn infants there ~~shall be no~~ may not be
3 waiting or elimination periods. A deductible or reduction in benefits applicable to the coverage for newborn
4 infants is not permissible unless it conforms and is consistent with the deductible or reduction in benefits
5 applicable to all other covered persons.

6 (3) ~~No~~ A policy or certificate of insurance may not be issued or amended in this state if it contains
7 any disclaimer, waiver, or other limitation of coverage relative to the accident and sickness coverage or
8 insurability of newborn infants of an insured from and after the moment of birth.

9 (4) ~~If payment of a specific premium or subscription fee is required to provide coverage for a child,~~
10 ~~the policy or contract may require that notification of birth of a newly born child and payment of the~~
11 ~~required premium or fees must be furnished to the insurer or nonprofit service or indemnity corporation~~
12 ~~within 31 days after the date of birth in order to have the coverage continue beyond such 31 day period.~~
13 The policy or contract may require notification of the birth of a child and payment of a required premium
14 or subscription fee to be furnished to the insurer or nonprofit or indemnity corporation within 31 days of
15 the birth in order to have the coverage extend beyond 31 days."

16
17 **Section 61.** Section 33-22-303, MCA, is amended to read:

18 **"33-22-303. Coverage for well-child care.** (1) Each medical expense policy of disability insurance
19 or certificate issued under the policy that is delivered, issued for delivery, renewed, extended, or modified
20 in this state by a disability insurer and that provides coverage for a family member of the insured or
21 subscriber must provide coverage for well-child care for children from the moment of birth through 2 years
22 of age. Benefits provided under this coverage are exempt from any deductible provision that may be in
23 force in the policy or certificate issued under the policy.

24 (2) Coverage for well-child care under subsection (1) must include:

25 (a) a history, physical examination, developmental assessment, anticipatory guidance, and
26 laboratory tests, according to the schedule of visits adopted under the early and periodic screening,
27 diagnosis, and treatment services program provided for in 53-6-101; and

28 (b) routine immunizations according to the schedule for immunizations recommended by the
29 immunization practices advisory committee of the U.S. department of health and human services.

30 (3) Minimum benefits may be limited to one visit payable to one provider for all of the services

provided at each visit cited in this section.

(4) This section does not apply to disability income, specified disease, medicare supplement, or hospital indemnity policies.

(5) For purposes of this section:

(a) "well-child care" means the services described in subsection (2) and delivered by a physician or a health care professional supervised by a physician; and

(b) "developmental assessment" and "anticipatory guidance" mean the services described in the Guidelines for Health Supervision II, published by the American academy of pediatrics.

(6) When a policy of disability insurance or a certificate issued under the policy provides coverage or benefits to a resident of this state, it is considered to be delivered in this state within the meaning of this section, whether the insurer that issued or delivered the policy or certificate is located inside or outside of this state."

Section 62. Section 33-22-504, MCA, is amended to read:

"33-22-504. Newborn infant coverage. (1) ~~No A~~ group disability policy or certificate of insurance which, in addition to covering persons in the insured group, also covers members of such person's family delivered or issued for delivery in this state may not be issued or amended in this state if it contains any disclaimer, waiver, or other limitation of coverage relative to the accident and sickness coverage or insurability of newborn infants of persons covered under the policy from and after the moment of birth.

(2) ~~If the A policy or certificate issued thereunder, in addition to covering persons in the insured group, also covers members of such person's family, it shall~~ subject to this section, must contain an ~~additional~~ a provision granting immediate accident and sickness coverage, from and after the moment of birth, to each newborn infant of any person covered under the policy.

(3) The coverage for newborn infants ~~shall~~ must be the same as provided by the policy for other covered persons; ~~provided, however~~ However, that for newborn infants there ~~shall~~ may not be ~~no~~ waiting or elimination periods. A deductible or reduction in benefits applicable to the coverage for newborn infants is not permissible unless it conforms and is consistent with the deductible or reduction in benefits applicable to all other covered persons.

(4) This section does not apply to medicare supplement policies issued by reason of age.

(5) When a group disability policy or certificate issued under the policy provides for coverage or

1 benefits for a resident of this state, the policy or certificate is considered delivered in this state within the
2 meaning of this section regardless of whether the insurer issuing the policy or certificate is located in this
3 state.

4 (6) The policy or certificate may require notification of the birth of a child and payment of a
5 required premium or subscription fee to be furnished to the insurer or nonprofit or indemnity corporation
6 within 31 days of the birth in order to have the coverage extend beyond 31 days."

7
8 **Section 63.** Section 33-22-508, MCA, is amended to read:

9 **"33-22-508. Conversion on termination of eligibility.** (1) A group disability insurance policy or
10 certificate of insurance delivered or issued for delivery or renewed after October 1, 1981, must contain a
11 provision that if the insurance or any portion of it on a person, ~~his~~ or the person's dependents, or family
12 members covered under the policy ceases because of termination of ~~his~~ the person's employment or ~~of his~~
13 membership in the class or classes eligible for coverage under the policy or as a result of ~~his~~ the person's
14 employer discontinuing ~~his~~ business or as a result of ~~his~~ the employer discontinuing the group disability
15 insurance policy and not providing for any other group disability insurance or plan and if the person had
16 been insured for a period of 3 months and ~~he~~ is not insured under another major medical disability insurance
17 policy or plan, ~~he~~ the person is entitled to have issued ~~to him~~ by the insurer, without evidence of
18 insurability, group coverage or an individual policy ~~issued by the insurer~~ or, in the absence of an individual
19 policy issued by the insurer, a group policy issued by the insurer, of hospital or medical service insurance
20 on ~~himself~~ the person, his and the person's dependents, or family members if application for the individual
21 policy is made and the first premium tendered to the insurer within 31 days after the termination of group
22 coverage.

23 (2) The individual policy or group policy, at the option of the insured, may be on any form then
24 customarily issued by the insurer to individual or group policyholders, with the exception of a policy the
25 eligibility for which is determined by affiliation other than by employment with a common entity.

26 (3) The premium on the individual policy or group policy must be at the insurer's then customary
27 rate applicable to the coverage of the individual or group policy."

28
29 **Section 64.** Section 33-22-1120, MCA, is amended to read:

30 **"33-22-1120. Extraterritorial jurisdiction.** A group long-term care insurance policy or certificate

may not be delivered or issued for delivery to a resident of Montana under a group policy issued in another state to a group described in 33-22-1107(3)(d) unless it is approved by:

(1) the commissioner; ~~or~~ and

(2) the insurance regulatory official of a state that has statutory and regulatory long-term care insurance requirements substantially similar to those adopted in Montana."

Section 65. Section 33-22-1803, MCA, is amended to read:

"33-22-1803. Definitions. As used in this part, the following definitions apply:

(1) "Actuarial certification" means a written statement by a member of the American academy of actuaries or other individual acceptable to the commissioner that a small employer carrier is in compliance with the provisions of 33-22-1809, based upon the person's examination, including a review of the appropriate records and of the actuarial assumptions and methods used by the small employer carrier in establishing premium rates for applicable health benefit plans.

(2) "Affiliate" or "affiliated" means any entity or person who directly or indirectly, through one or more intermediaries, controls, is controlled by, or is under common control with a specified entity or person.

(3) "Assessable carrier" means all individual carriers of disability insurance and all carriers of group disability insurance, excluding the state group benefits plan provided for in Title 2, chapter 18, part 8, the Montana university system health plan, and any self-funded disability insurance plan provided by a political subdivision of the state.

(4) "Base premium rate" means, for each class of business as to a rating period, the lowest premium rate charged or that could have been charged under the rating system for that class of business by the small employer carrier to small employers with similar case characteristics for health benefit plans with the same or similar coverage.

(5) "Basic health benefit plan" means a lower cost health benefit plan developed pursuant to 33-22-1812.

(6) "Board" means the board of directors of the program established pursuant to 33-22-1818.

(7) "Carrier" means any person who provides a health benefit plan in this state subject to state insurance regulation. The term includes but is not limited to an insurance company, a fraternal benefit society, a health service corporation, a health maintenance organization, and, to the extent permitted by the Employee Retirement Income Security Act of 1974, a multiple-employer welfare arrangement. For

1 purposes of this part, companies that are affiliated companies or that are eligible to file a consolidated tax
2 return must be treated as one carrier, except that the following may be considered as separate carriers:

3 (a) an insurance company or health service corporation that is an affiliate of a health maintenance
4 organization located in this state;

5 (b) a health maintenance organization located in this state that is an affiliate of an insurance
6 company or health service corporation; or

7 (c) a health maintenance organization that operates only one health maintenance organization in
8 an established geographic service area of this state.

9 (8) "Case characteristics" means demographic or other objective characteristics of a small employer
10 that are considered by the small employer carrier in the determination of premium rates for the small
11 employer, provided that gender, claims experience, health status, and duration of coverage are not case
12 characteristics for purposes of this part.

13 (9) "Class of business" means all or a separate grouping of small employers established pursuant
14 to 33-22-1808.

15 (10) "Committee" means the health benefit plan committee created pursuant to 33-22-1812.

16 (11) "Dependent" means:

17 (a) a spouse or an unmarried child under 19 years of age;

18 (b) an unmarried child, under 23 years of age, who is a full-time student and who is financially
19 dependent on the insured;

20 (c) a child of any age who is disabled and dependent upon the parent as provided in 33-22-506
21 and 33-30-1003; or

22 (d) any other individual defined ~~to be~~ as a dependent in the health benefit plan covering the
23 employee.

24 (12) "Eligible employee" means an employee who works on a full-time basis and who has a normal
25 workweek of 30 hours or more. The term includes a sole proprietor, a partner of a partnership, and an
26 independent contractor if the sole proprietor, partner, or independent contractor is included as an employee
27 under a health benefit plan of a small employer. The term does not include an employee who works on a
28 part-time, temporary, or substitute basis.

29 (13) "Established geographic service area" means a geographic area, as approved by the
30 commissioner and based on the carrier's certificate of authority to transact insurance in this state, within

1 which the carrier is authorized to provide coverage.

2 (14) "Health benefit plan" means any hospital or medical policy or certificate providing for physical
3 and mental health care issued by an insurance company, a fraternal benefit society, or a health service
4 corporation or issued under a health maintenance organization subscriber contract. Health benefit plan does
5 not include:

6 (a) accident-only, credit, dental, vision, specified disease, medicare supplement, long-term care,
7 or disability income insurance;

8 (b) coverage issued as a supplement to liability insurance, workers' compensation insurance, or
9 similar insurance; or

10 (c) automobile medical payment insurance.

11 (15) "Index rate" means, for each class of business for a rating period for small employers with
12 similar case characteristics, the average of the applicable base premium rate and the corresponding highest
13 premium rate.

14 (16) "Late enrollee" means an eligible employee or dependent who requests enrollment in a health
15 benefit plan of a small employer following the initial enrollment period during which the individual was
16 entitled to enroll under the terms of the health benefit plan, provided that the initial enrollment period was
17 a period of at least 30 days. However, an eligible employee or dependent may not be considered a late
18 enrollee if:

19 (a) the individual requests enrollment within 30 days after termination of the qualifying previous
20 coverage and meets each of the following conditions:

21 (i) the individual was covered under qualifying previous coverage at the time of the initial
22 enrollment; or

23 (ii) the individual lost coverage under qualifying previous coverage as a result of termination of
24 employment or eligibility, the involuntary termination of the qualifying previous coverage, the death of a
25 spouse, or divorce; ~~and~~

26 ~~(iii) the individual requests enrollment within 30 days after termination of the qualifying previous~~
27 ~~coverage;~~

28 (b) the individual is employed by an employer that offers multiple health benefit plans and the
29 individual elects a different plan during an open enrollment period; or

30 (c) a court has ordered that coverage be provided for a spouse, minor, or dependent child under

1 a covered employee's health benefit plan and a request for enrollment is made within 30 days after issuance
2 of the court order.

3 (17) "New business premium rate" means, for each class of business for a rating period, the lowest
4 premium rate charged or offered or that could have been charged or offered by the small employer carrier
5 to small employers with similar case characteristics for newly issued health benefit plans with the same or
6 similar coverage.

7 (18) "Plan of operation" means the operation of the program established pursuant to 33-22-1818.

8 (19) "Premium" means all money paid by a small employer and eligible employees as a condition
9 of receiving coverage from a small employer carrier, including any fees or other contributions associated
10 with the health benefit plan.

11 (20) "Program" means the Montana small employer health reinsurance program created by
12 33-22-1818.

13 (21) "Qualifying previous coverage" means benefits or coverage provided under:

14 (a) medicare or medicaid;

15 (b) an employer-based health insurance or health benefit arrangement that provides benefits similar
16 to or exceeding benefits provided under the basic health benefit plan; or

17 (c) an individual health insurance policy, including coverage issued by an insurance company, a
18 fraternal benefit society, a health service corporation, or a health maintenance organization that provides
19 benefits similar to or exceeding the benefits provided under the basic health benefit plan, provided that the
20 policy has been in effect for a period of at least 1 year.

21 (22) "Rating period" means the calendar period for which premium rates established by a small
22 employer carrier are assumed to be in effect.

23 (23) "Reinsuring carrier" means a small employer carrier participating in the reinsurance program
24 pursuant to 33-22-1819.

25 (24) "Restricted network provision" means a provision of a health benefit plan that conditions the
26 payment of benefits, in whole or in part, on the use of health care providers that have entered into a
27 contractual arrangement with the carrier pursuant to Title 33, chapter 22, part 17, or Title 33, chapter 31,
28 to provide health care services to covered individuals.

29 (25) "Small employer" means a person, firm, corporation, partnership, or association that is actively
30 engaged in business and that, on at least 50% of its working days during the preceding calendar quarter,

employed at least 3 but not more than 25 eligible employees, the majority of whom were employed within this state or were residents of this state. In determining the number of eligible employees, companies are considered one employer if they:

(a) are affiliated companies;

(b) are eligible to file a combined tax return for purposes of state taxation; or

(c) are members of an association that:

(i) has been in existence for 1 year prior to January 1, 1994;

(ii) provides a health benefit plan to employees of its members as a group; and

(iii) does not deny coverage to any member of its association or any employee of its members who applies for coverage as part of a group.

(26) "Small employer carrier" means a carrier that offers health benefit plans that cover eligible employees of one or more small employers in this state.

(27) "Standard health benefit plan" means a health benefit plan developed pursuant to 33-22-1812."

Section 66. Section 33-22-1819, MCA, is amended to read:

"33-22-1819. Program plan of operation -- treatment of losses -- exemption from taxation. (1)

Within 180 days after the appointment of the initial board, the board shall submit to the commissioner a plan of operation and may at any time submit amendments to the plan necessary or suitable to ensure the fair, reasonable, and equitable administration of the program. The commissioner may, after notice and hearing, approve the plan of operation if the commissioner determines it to be suitable to ensure the fair, reasonable, and equitable administration of the program and if the plan of operation provides for the sharing of program gains or losses on an equitable and proportionate basis in accordance with the provisions of this section. The plan of operation is effective upon written approval by the commissioner.

(2) If the board fails to submit a suitable plan of operation within 180 days after its appointment, the commissioner shall, after notice and hearing, promulgate and adopt a temporary plan of operation. The commissioner shall amend or rescind any temporary plan adopted under this subsection at the time a plan of operation is submitted by the board and approved by the commissioner.

(3) The plan of operation must:

(a) establish procedures for the handling and accounting of program assets and money and for an

- 1 annual fiscal reporting to the commissioner;
- 2 (b) establish procedures for selecting an administering carrier and setting forth the powers and
3 duties of the administering carrier;
- 4 (c) establish procedures for reinsuring risks in accordance with the provisions of this section;
- 5 (d) establish procedures for collecting assessments from assessable carriers to fund claims incurred
6 by the program;
- 7 (e) establish procedures for allocating a portion of premiums collected from reinsuring carriers to
8 fund administrative expenses incurred or to be incurred by the program; and
- 9 (f) provide for any additional matters necessary for the implementation and administration of the
10 program.
- 11 (4) The program has the general powers and authority granted under the laws of this state to
12 insurance companies and health maintenance organizations licensed to transact business, except the power
13 to issue health benefit plans directly to either groups or individuals. In addition, the program may:
- 14 (a) enter into contracts as are necessary or proper to carry out the provisions and purposes of this
15 part, including the authority, with the approval of the commissioner, to enter into contracts with similar
16 programs of other states for the joint performance of common functions or with persons or other
17 organizations for the performance of administrative functions;
- 18 (b) sue or be sued, including taking any legal actions necessary or proper to recover any premiums
19 and penalties for, on behalf of, or against the program or any reinsuring carriers;
- 20 (c) take any legal action necessary to avoid the payment of improper claims against the program;
- 21 (d) define the health benefit plans for which reinsurance will be provided and to issue reinsurance
22 policies in accordance with the requirements of this part;
- 23 (e) establish conditions and procedures for reinsuring risks under the program;
- 24 (f) establish actuarial functions as appropriate for the operation of the program;
- 25 (g) appoint appropriate legal, actuarial, and other committees as necessary to provide technical
26 assistance in operation of the program, policy and other contract design, and any other function within the
27 authority of the program;
- 28 (h) to the extent permitted by federal law and in accordance with subsection (8)(c), make annual
29 fiscal yearend assessments against assessable carriers and make interim assessments to fund claims
30 incurred by the program; and

1 (i) borrow money to effect the purposes of the program. Any notes or other evidence of
2 indebtedness of the program not in default are legal investments for carriers and may be carried as admitted
3 assets.

4 (5) A reinsuring carrier may reinsure with the program as provided for in this subsection (5):

5 (a) With respect to a basic health benefit plan or a standard health benefit plan, the program shall
6 reinsure the level of coverage provided and, with respect to other plans, the program shall reinsure up to
7 the level of coverage provided in a basic or standard health benefit plan.

8 (b) A small employer carrier may reinsure an entire employer group within 60 days of the
9 commencement of the group's coverage under a health benefit plan.

10 (c) A reinsuring carrier may reinsure an eligible employee or dependent within a period of 60 days
11 following the commencement of coverage with the small employer. A newly eligible employee or dependent
12 of the reinsured small employer may be reinsured within 60 days of the commencement of coverage.

13 (d) (i) The program may not reimburse a reinsuring carrier with respect to the claims of a reinsured
14 employee or dependent until the carrier has incurred an initial level of claims for the employee or dependent
15 of \$5,000 in a calendar year for benefits covered by the program. In addition, the reinsuring carrier is
16 responsible for 20% of the next \$100,000 of benefit payments during a calendar year and the program
17 shall reinsure the remainder. A reinsuring carrier's liability under this subsection (d)(i) may not exceed a
18 maximum limit of \$25,000 in any calendar year with respect to any reinsured individual.

19 (ii) The board annually shall adjust the initial level of claims and maximum limit to be retained by
20 the carrier to reflect increases in costs and utilization within the standard market for health benefit plans
21 within the state. The adjustment may not be less than the annual change in the medical component of the
22 consumer price index for all urban consumers of the United States department of labor, bureau of labor
23 statistics, unless the board proposes and the commissioner approves a lower adjustment factor.

24 (e) A small employer carrier may terminate reinsurance with the program for one or more of the
25 reinsured employees or dependents of a small employer on any anniversary of the health benefit plan.

26 (f) A small employer group health benefit plan in effect before January 1, 1994, may not be
27 reinsured by the program until January 1, 1997, and then only if the board determines that sufficient
28 funding sources are available.

29 (g) A reinsuring carrier shall apply all managed care and claims-handling techniques, including
30 utilization review, individual case management, preferred provider provisions, and other managed care

1 provisions or methods of operation consistently with respect to reinsured and nonreinsured business.

2 (6) (a) As part of the plan of operation, the board shall establish a methodology for determining
3 premium rates to be charged by the program for reinsuring small employers and individuals pursuant to this
4 section. The methodology must include a system for classification of small employers that reflects the types
5 of case characteristics commonly used by small employer carriers in the state. The methodology must
6 provide for the development of base reinsurance premium rates that must be multiplied by the factors set
7 forth in subsection (6)(b) to determine the premium rates for the program. The base reinsurance premium
8 rates must be established by the board, subject to the approval of the commissioner, and must be set at
9 levels that reasonably approximate gross premiums charged to small employers by small employer carriers
10 for health benefit plans with benefits similar to the standard health benefit plan, adjusted to reflect retention
11 levels required under this part.

12 (b) Premiums for the program are as follows:

13 (i) An entire small employer group may be reinsured for a rate that is one and one-half times the
14 base reinsurance premium rate for the group established pursuant to this subsection (6).

15 (ii) An eligible employee or dependent may be reinsured for a rate that is five times the base
16 reinsurance premium rate for the individual established pursuant to this subsection (6).

17 (c) The board periodically shall review the methodology established under subsection (6)(a),
18 including the system of classification and any rating factors, to ensure that it reasonably reflects the claims
19 experience of the program. The board may propose changes to the methodology that are subject to the
20 approval of the commissioner.

21 (d) The board may consider adjustments to the premium rates charged by the program to reflect
22 the use of effective cost containment and managed care arrangements.

23 (7) If a health benefit plan for a small employer is entirely or partially reinsured with the program,
24 the premium charged to the small employer for any rating period for the coverage issued must meet the
25 requirements relating to premium rates set forth in 33-22-1809.

26 (8) (a) Prior to March 1 of each year, the board shall determine and report to the commissioner the
27 program net loss for the previous calendar year, including administrative expenses and incurred losses for
28 the year, taking into account investment income and other appropriate gains and losses.

29 (b) To the extent permitted by federal law, each assessable carrier shall share in any net loss of
30 the program for the year in an amount equal to the ratio of the total premiums earned in the previous

1 calendar year from health benefit plans delivered or issued for delivery by each assessable carrier divided
2 by the total premiums earned in the previous calendar year from health benefit plans delivered or issued
3 for delivery by all assessable carriers in the state.

4 (c) The board shall make an annual determination in accordance with this section of each
5 assessable carrier's liability for its share of the net loss of the program and, except as otherwise provided
6 by this section, make an annual fiscal yearend assessment against each assessable carrier to the extent of
7 that liability. If approved by the commissioner, the board may also make interim assessments against
8 assessable carriers to fund claims incurred by the program. Any interim assessment must be credited
9 against the amount of any fiscal yearend assessment due or to be due from an assessable carrier. Payment
10 of a fiscal yearend or interim assessment is due within 30 days of receipt by the assessable carrier of
11 written notice of the assessment. An assessable carrier that ceases doing business within the state is liable
12 for assessments until the end of the calendar year in which the assessable carrier ceased doing business.
13 The board may determine not to assess an assessable carrier if the assessable carrier's liability determined
14 in accordance with this section does not exceed \$10.

15 (9) The participation in the program as reinsuring carriers; the establishment of rates, forms, or
16 procedures; or any other joint collective action required by this part may not be the basis of any legal
17 action, criminal or civil liability, or penalty against the program or any of its reinsuring carriers, either jointly
18 or separately.

19 (10) The board, as part of the plan of operation, shall develop standards setting forth the minimum
20 levels of compensation to be paid to producers for the sale of basic and standard health benefit plans. In
21 establishing the standards, the board shall take into consideration the need to ensure the broad availability
22 of coverages, the objectives of the program, the time and effort expended in placing the coverage, the need
23 to provide ongoing service to small employers, the levels of compensation currently used in the industry,
24 and the overall costs of coverage to small employers selecting these plans.

25 (11) The program is exempt from taxation.

26 (12) On or before March 1 of each year, the commissioner shall evaluate the operation of the
27 program and report to the governor and the legislature in writing the results of the evaluation. The report
28 must include an estimate of future costs of the program, assessments necessary to pay those costs, the
29 appropriateness of premiums charged by the program, the level of insurance retention under the program,
30 the cost of coverage of small employers, and any recommendations for change to the plan of operation.

1 (13) All premiums and other money paid to the small employer carrier reinsurance program and all
2 property and securities acquired through the use of money and interest and dividends earned on money
3 belonging to the small employer carrier reinsurance program are solely the property of the program and
4 must be used exclusively for the operations and obligations of the program. Money collected by the
5 program is not subject to legislative appropriation."

6
7 **Section 67.** Section 33-30-102, MCA, is amended to read:

8 **"33-30-102. Application of this chapter -- construction of other related laws.** (1) All health service
9 corporations ~~heretofore or hereafter organized~~ are subject to the provisions of this chapter. In addition to
10 the provisions contained in this chapter, other chapters and provisions of this title apply to health service
11 corporations as follows: ~~33-17-212 33-17-101; through 33-17-214~~ Title 33, chapter 17, parts 2 and 10
12 through 12; and Title 33, chapters 1, 15, 18, 19, and 22, except 33-22-111; and [sections 78 through 81].

13 (2) A law of this state other than the provisions of this chapter applicable to health service
14 corporations ~~shall~~ must be construed in accordance with the fundamental nature of a health service
15 corporation, and in the event of a conflict ~~between that law and the provisions of this chapter, the latter~~
16 shall prevail."

17
18 **Section 68.** Section 33-30-107, MCA, is amended to read:

19 **"33-30-107. Annual statement.** (1) On or before March 1 of each year, Every each health service
20 corporation shall file an annual statement for the preceding year on a form containing substantially the same
21 ~~information as that contained in form No. 13 N.A.I.C. with the commissioner of insurance. This annual~~
22 statement must be completed in accordance with the national association of insurance commissioners'
23 annual statement instructions.

24 (2) The health service corporation shall file a statement containing any other information concerning
25 its financial affairs that may be reasonably requested by the commissioner.

26 (3) (a) Each health service corporation shall file electronic diskette versions of its annual and
27 quarterly financial statements with the national association of insurance commissioners. The filing date for
28 submission of the annual statement diskette is March 1. The filing dates for the other three quarterly
29 statements are as follows:

30 (i) the first quarter statement is due May 15;

1 (ii) the second quarter statement is due August 15; and

2 (iii) the third quarter statement is due November 15.

3 (b) The commissioner may exempt health service corporations operating only in Montana from
4 these filing requirements."

5
6 **Section 69.** Section 33-30-108, MCA, is amended to read:

7 **"33-30-108. License required.** (1) ~~No~~ A person may not act as a health service corporation and
8 ~~no~~ a health service corporation may not conduct business in this state except as authorized by a license
9 issued by the commissioner.

10 (2) ~~Such~~ A license may be issued by the commissioner only after the person has complied with the
11 applicable provisions of this title.

12 (3) A health service corporation is entitled to a continuation of its license upon payment of the
13 annual continuation fee specified in 33-30-204~~(1)(i)~~ on or before March 1 of each year and upon continued
14 compliance with the provisions of this title.

15 (4) A license issued or continued under this section may be revoked or suspended by the
16 commissioner for violation of this title."

17
18 **Section 70.** Section 33-30-202, MCA, is amended to read:

19 **"33-30-202. Annual report by certified public accountant.** (1) All corporations subject to the
20 provisions of this chapter shall ~~make and~~ file annually with the commissioner, on or before ~~March~~ June 1
21 ~~of each year, a report under oath setting forth:~~ financial statement audited by a certified public accountant
22 pursuant to rules promulgated by the commissioner.

23 ~~(1) the name of the corporation;~~

24 ~~(2) the address of its registered office in this state and the name of its registered agent at that~~
25 ~~address;~~

26 ~~(3) the names and addresses of its directors and officers;~~

27 ~~(4) a brief statement of the character of the affairs which the corporation is actually conducting;~~

28 ~~(5) the amount of all dues or fees collected from members in the last fiscal year, the amounts~~
29 ~~actually paid during that year for health services for the members or beneficiaries, and the amounts placed~~
30 ~~in reserves;~~

~~(6) a balance sheet and statement of income and expenditures for the most recent fiscal year of the corporation, prepared and verified by two officers of the corporation and certified by a certified public accountant;~~

~~(7) a statement of any other facts or information concerning the financial affairs of the health service corporation which may be reasonably required by the commissioner.~~

(2) (a) The commissioner may establish rules governing the content and preparation of the report required by subsection (1).

(b) The report must include:

(i) the corporation's financial statements for the most recent calendar year;

(ii) an opinion by the certified public accountant concerning the accuracy and fairness of the corporation's representation of its financial statements; and

(iii) other information that the commissioner specifies by rule."

Section 71. Section 33-30-204, MCA, is amended to read:

"33-30-204. Fees. (1) Every health service corporation subject to the provisions of this chapter shall pay the following fees to the commissioner for enforcement of the provisions of this chapter:

~~(a) insurance producer's license;~~

~~(i) application for original license and issuance of license \$15~~

~~(ii) annual renewal \$15~~

~~(iii) examination for license, for each examination \$15~~

~~(b)(a)~~ filing any other statement or report \$1

~~(c)(b)~~ for a certified copy of any document or other paper filed in the office of the commissioner, per page \$.50

~~(d)(c)~~ for the a certificate and for affixing the with affixed seal thereto \$10

~~(e)(d)~~ filing of a membership contract \$25

~~(f)(e)~~ filing of a membership contract package \$100

~~(g)(f)~~ filing annual report, other than as part of application for original license \$25

~~(h)(g)~~ issuance of health service corporation license \$300

~~(i)(h)~~ annual continuation of health service corporation license \$300

(2) The commissioner shall promptly deposit with the state treasurer, to the credit of the general

fund, all fees and license fees received ~~by him~~ under this section."

Section 72. Section 33-30-311, MCA, is amended to read:

"33-30-311. Insurance producer. ~~(1)~~ A person who, for compensation, solicits membership in a prepayment health service plan offered by a corporation subject to the provisions of this chapter is an insurance producer of that corporation and is subject to the provisions of 33-2-708 and Title 33, chapter 17.

~~(2) The definitions of insurance producer as defined in this chapter do not include an individual:~~

~~(a) employed and used by insurance producers for the performance of clerical, stenographic, and similar office duties;~~

~~(b) employed and used for incidental taking of an application for coverage from time to time in the office of the employing insurance producer;~~

~~(c) who secures and forwards information for the purpose of an existing group contractor for enrolling individuals under an existing group contract."~~

Section 73. Section 33-30-1001, MCA, is amended to read:

"33-30-1001. Newborn infants covered by insurance by health service corporation. ~~No~~ A disability insurance plan or group disability insurance plan issued by a health service corporation may not be issued or amended in this state if it contains any disclaimer, waiver, or other limitation of coverage relative to the accident and sickness coverage or insurability of newborn infants of the persons insured from and after the moment of birth. Each ~~such~~ policy ~~shall~~ must contain a provision granting immediate accident and sickness coverage, from and after the moment of birth, to each newborn infant of any insured person. ~~If payment of a specific premium or subscription fee is required to provide coverage for a child, the policy or contract may require that notification of birth of a newly born child and payment of the required premium or fees must be furnished to the insurer or nonprofit service or indemnity corporation within 31 days after the date of birth in order to have the coverage continue beyond such 31 day period. The policy or contract may require notification of the birth of a child and payment of a required premium or subscription fee to be furnished to the insurer or nonprofit or indemnity corporation within 31 days of the birth in order to have the coverage extend beyond 31 days."~~

1 **Section 74.** Section 33-31-311, MCA, is amended to read:

2 **"33-31-311. Insurance producer license required -- application, issuance, renewal, fees -- penalty.**

3 (1) ~~No~~ An individual, partnership, or corporation may not act as or ~~hold himself out~~ represent to the public
4 to be an insurance producer of a health maintenance organization unless ~~he~~ the individual, partnership, or
5 corporation is:

6 (a) licensed as a disability insurance producer by the commissioner pursuant to chapter 17, parts
7 1, 2, and 4 of this title or licensed as an insurance producer under 33-30-311 ~~through 33-30-313~~; and

8 (b) appointed or authorized by the health maintenance organization to solicit health care service
9 agreements on its behalf.

10 (2) Application, appointment and qualification for a health maintenance organization insurance
11 producer license, fees applicable to and the issuance of a health maintenance organization insurance
12 producer license, and renewal of a health maintenance organization insurance producer license must be in
13 accordance with the provisions of chapter 17 that apply to a disability insurance producer.

14 (3) An individual, partnership, or corporation who holds a disability insurance producer license on
15 October 1, 1987, need not requalify by an examination to be licensed as a health maintenance organization
16 insurance producer.

17 (4) The commissioner may, in accordance with 33-1-313, 33-1-317, 33-17-411, and chapter 17,
18 part 10, suspend, revoke, refuse to issue or renew a health maintenance organization insurance producer
19 license, or impose a fine upon the licensee.

20 (5) The provisions of this section do not exempt a health maintenance organization from material
21 transaction disclosure requirements under [sections 78 through 81]. A health maintenance organization
22 must be considered an insurer for the purposes of [sections 78 through 81]."

23
24 **NEW SECTION. Section 75. Notice of right to return policy.** Each life or disability insurance policy,
25 except a single-premium nonrenewable disability policy, issued for delivery in this state or issued after
26 January 1, 1996, must contain a notice stating in substance that if the person to whom the policy is issued
27 is not satisfied for any reason, the person may return the policy within 10 days of its delivery or a longer
28 period if provided by the policy and have refunded directly to the person the premium paid. A policy
29 returned pursuant to this section is void from the beginning.

30

1 **NEW SECTION.** **Section 76. Reserve calculation -- indeterminate premium plans -- minimum**
2 **standards for disability plans.** (1) In the case of a plan of life insurance that provides for future premium
3 determination, the amounts of which are to be determined by the insurer based on then estimates of future
4 experience, or in the case of a plan of life insurance or annuity that is of such a nature that the minimum
5 reserves cannot be determined by the methods described in 33-2-525 and 33-2-526(3), the reserves that
6 are held under the plan must:

7 (a) be appropriate in relation to the benefits and the pattern of premiums for that plan; and

8 (b) be computed by a method that is consistent with the principles of 33-2-521 through 33-2-529,
9 as determined by rules promulgated by the commissioner.

10 (2) The commissioner shall promulgate a rule containing the minimum standards applicable to the
11 valuation of disability plans.

12
13 **NEW SECTION.** **Section 77. Dating of insurance applications -- antedating prohibited.** An
14 application for issuance of an insurance policy may not be antedated by any person in order to obtain or
15 provide coverage for losses or injuries incurred prior to the date of application.

16
17 **NEW SECTION.** **Section 78. Short title.** [Sections 78 through 81] may be cited as the "Disclosure
18 of Material Transactions Act".

19
20 **NEW SECTION.** **Section 79. Report.** (1) An insurer domiciled in this state shall file a report with
21 the commissioner disclosing material acquisitions and dispositions of assets or material nonrenewals,
22 cancellations, or revisions of ceded reinsurance agreements unless the acquisitions and dispositions of
23 assets or material nonrenewals, cancellations, or revisions have been submitted to the commissioner for
24 review or approval or for information purposes pursuant to other provisions of the insurance code, laws,
25 or regulations or other requirements.

26 (2) The report required in subsection (1) is due within 15 days after the end of the calendar month
27 in which any of the transactions in subsection (1) occur.

28 (3) One complete copy of the report, including any exhibits or other attachments, must be filed
29 with:

30 (a) the insurance department of the state in which the insurer is domiciled; and

1 (b) the national association of insurance commissioners.

2 (4) All reports obtained by or disclosed to the commissioner pursuant to [sections 78 through 81]
3 must be treated confidentially, may not be subject to subpoena, and may not be made public by the
4 commissioner, the national association of insurance commissioners, or any other person, except to
5 insurance departments of other states, without the prior consent of the insurer to which it pertains unless
6 the commissioner, after giving the insurer notice and an opportunity to be heard, determines that the
7 interest of policyholders, shareholders, or the public will be served by publication, in which event the
8 commissioner may publish all or any part of the report in the manner the commissioner chooses.

9
10 NEW SECTION. **Section 80. Acquisitions and dispositions of assets.** (1) Acquisitions or
11 dispositions of assets that are not material are not required to be reported pursuant to [section 79] if the
12 acquisitions or dispositions are not material. For purposes of [sections 78 through 81], a material
13 acquisition or the aggregate of any series of related acquisitions during any 30-day period or a disposition
14 or the aggregate of any series of related dispositions during any 30-day period is one that is nonrecurring
15 and not in the ordinary course of business and involves more than 5% of the reporting insurer's total
16 admitted assets as reported in its most recent statutory statement filed with the insurance department of
17 the insurer's state of domicile.

18 (2) Asset acquisitions subject to [sections 78 through 81] include every purchase, lease, exchange,
19 merger, consolidation, succession, or other acquisition, other than the construction or development of real
20 property, by or for the reporting insurer or the acquisition of materials for this purpose.

21 (3) Asset dispositions subject to [sections 78 through 81] include each sale, lease, exchange,
22 merger, consolidation, mortgage, hypothecation, assignment, whether for the benefit of creditors or
23 otherwise, abandonment, destruction, or other disposition.

24 (4) The following information is required to be disclosed in any report of a material acquisition or
25 disposition of assets:

26 (a) the date of the transaction;

27 (b) the manner of acquisition or disposition;

28 (c) the description of the assets involved;

29 (d) the nature and amount of the consideration given or received;

30 (e) the purpose or reason for the transaction;

1 (f) the manner by which the amount of consideration was determined;

2 (g) the gain or loss recognized or realized as a result of the transaction; and

3 (h) the names of the persons from whom the assets were acquired or to whom they were disposed.

4 (5) An insurer is required to report material acquisitions and dispositions on a nonconsolidated basis
5 unless the insurer is part of a consolidated group of insurers that uses a pooling arrangement or 100%
6 reinsurance agreement that affects the solvency and integrity of the insurer's reserves and the insurer
7 ceded substantially all of its direct and assumed business to the pool. An insurer cedes substantially all
8 of its direct and assumed business to a pool if the insurer has less than \$1 million total direct plus assumed
9 written premiums during a calendar year that are not subject to a pooling arrangement and the net income
10 of the business not subject to the pooling arrangement represents less than 5% of the insurer's capital and
11 surplus.

12
13 **NEW SECTION. Section 81. Nonrenewals, cancellations, or revisions of ceded reinsurance**
14 **agreements.** (1) A nonrenewal, cancellation, or revision of a ceded reinsurance agreement need not
15 be reported pursuant to [section 79] if the nonrenewal, cancellation, or revision is not material. For
16 purposes of [sections 78 through 81], a material nonrenewal, cancellation, or revision is one that
17 affects:

18 (a) property and casualty business, including disability business written by a property and
19 casualty insurer, so that:

20 (i) more than 50% of the insurer's total ceded written premium is affected; or

21 (ii) more than 50% of the insurer's total ceded indemnity and loss adjustment reserves are
22 affected;

23 (b) life, annuity, and disability business, so that more than 50% of the total reserve credit taken
24 for business ceded, on an annualized basis, as indicated in the insurer's most recent annual statement
25 is affected;

26 (c) either property and casualty or life, annuity, and disability business and causes either of the
27 following events that constitutes a material revision that must be reported:

28 (i) an authorized reinsurer representing more than 10% of a total cession is replaced by one
29 or more unauthorized reinsurers; or

30 (ii) previously established collateral requirements have been reduced or waived as respects one

1 or more unauthorized reinsurers representing collectively more than 10% of a total cession.

2 (2) However, a filing is not required if:

3 (a) with respect to property and casualty business, including disability business written by a
4 property and casualty insurer, the insurer's total ceded written premium represents, on an annualized
5 basis, less than 10% of its total written premium for direct and assumed business; or

6 (b) with respect to life, annuity, and disability business, the total reserve credit taken for
7 business ceded represents, on an annualized basis, less than 10% of the statutory reserve requirement
8 prior to any cession.

9 (3) The following information is required to be disclosed in any report of a material nonrenewal,
10 cancellation, or revision of ceded reinsurance agreements:

11 (a) the effective date of the nonrenewal, cancellation, or revision;

12 (b) the description of the transaction with an identification of the initiator of the transaction;

13 (c) the purpose or reason for the transaction; and

14 (d) if applicable, the identity of the replacement reinsurers.

15 (4) Insurers are required to report all material nonrenewals, cancellations, or revisions of ceded
16 reinsurance agreements on a nonconsolidated basis unless the insurer is part of a consolidated group
17 of insurers that uses a pooling arrangement or 100% reinsurance agreement that affects the solvency
18 and integrity of the insurer's reserves and the insurer ceded substantially all of its direct and assumed
19 business to the pool. An insurer is considered to have ceded substantially all of its direct and assumed
20 business to a pool if the insurer has less than \$1 million total direct plus assumed written premiums
21 during a calendar year that are not subject to a pooling arrangement and the net income of the business
22 not subject to the pooling arrangement represents less than 5% of the insurer's capital and surplus.

23
24 **NEW SECTION. Section 82. Short title.** [Sections 82 through 94] constitute and may be
25 referred to as "The Risk-Based Capital For Insurers Act".

26
27 **NEW SECTION. Section 83. Definitions.** As used in [sections 82 through 94], the following
28 definitions apply:

29 (1) "Adjusted RBC report" means an RBC report that has been adjusted by the commissioner
30 in accordance with [section 84(5)].

1 (2) "Corrective order" means an order issued by the commissioner specifying corrective actions
2 that the commissioner has determined are required.

3 (3) "Domestic insurer" means any insurance company domiciled in this state.

4 (4) "Foreign insurer" means any insurance company licensed to do business in this state under
5 33-2-116 but not domiciled in this state.

6 (5) "Life or disability insurer" means:

7 (a) any insurance company licensed under 33-2-116 and engaged in the business of entering
8 into contracts of disability insurance as described in 33-1-207 or life insurance as described in
9 33-1-208; or

10 (b) a licensed property and casualty insurer writing only disability insurance.

11 (6) "NAIC" means the national association of insurance commissioners.

12 (7) "Negative trend" means, with respect to a life or health insurer, a negative trend over a
13 period of time, as determined in accordance with the trend test calculation included in the RBC
14 instructions.

15 (8) (a) "Property and casualty insurer" means any insurance company licensed under 33-2-116
16 and engaged in the business of entering into contracts of property insurance as described in 33-1-210
17 or casualty insurance as described in 33-1-206.

18 (b) The term does not include monoline mortgage guaranty insurers, financial guaranty insurers,
19 and title insurers.

20 (9) "RBC instructions" means the RBC report including risk-based capital instructions adopted
21 by the NAIC, as the RBC instructions may be amended by the NAIC from time to time in accordance
22 with the procedures adopted by the NAIC.

23 (10) "RBC level" means an insurer's authorized control level RBC, company action level RBC,
24 mandatory control level RBC, or regulatory action level RBC, where:

25 (a) "authorized control level RBC" means the number determined under the risk-based capital
26 formula in accordance with the RBC instructions;

27 (b) "company action level RBC" means, with respect to any insurer, the product of 2 and its
28 authorized control level RBC;

29 (c) "mandatory control level RBC" means the product of 0.70 and the authorized control level
30 RBC; and

(d) "regulatory action level RBC" means the product of 1.5 and its authorized control level RBC.

(11) "RBC plan" means a comprehensive financial plan containing the elements specified in [section 85(2)]. If the commissioner rejects the RBC plan and it is revised by the insurer, with or without the commissioner's recommendation, the plan must be called a revised RBC plan.

(12) "RBC report" means the report required in [section 84].

(13) "Total adjusted capital" means the sum of:

(a) an insurer's statutory capital and surplus; and

(b) other items, if any, as the RBC instructions may provide.

NEW SECTION. Section 84. RBC reports. (1) Each domestic insurer shall, on or before each March 1 filing date, prepare and submit to the commissioner a report of its RBC levels as of the end of the previous calendar year in a form and containing information as required by the RBC instructions. In addition, each domestic insurer shall file its RBC report:

(a) with the NAIC in accordance with the RBC instructions; and

(b) with the insurance commissioner in any state in which the insurer is authorized to do business if that insurance commissioner has notified the insurer of the request in writing, in which case the insurer shall file its RBC report not later than the later of:

(i) 15 days from the receipt of notice to file its RBC report with that state; or

(ii) the March 1 filing date.

(2) A life and disability insurer's RBC must be determined in accordance with the formula set forth in the RBC instructions. The formula must take into account and may adjust for the covariance between:

(a) the risk with respect to the insurer's assets;

(b) the risk of adverse insurance experience with respect to the insurer's liabilities and obligations;

(c) the interest rate risk with respect to the insurer's business; and

(d) all other business risks and other relevant risks as are set forth in the RBC instructions and determined in each case by applying the factors in the manner set forth in the RBC instructions.

(3) A property and casualty insurer's RBC must be determined in accordance with the formula set forth in the RBC instructions. The formula shall take into account and may adjust for the covariance

1 between:

2 (a) asset risk;

3 (b) credit risk;

4 (c) underwriting risk; and

5 (d) all other business risks and other relevant risks that are set forth in the RBC instructions
6 and determined in each case by applying the factors in the manner set forth in the RBC instructions.

7 (4) An excess of capital over the amount produced by the risk-based capital requirements
8 contained in [sections 82 through 94] and the formulas, schedules, and instructions referenced in
9 [sections 87 through 94] is desirable in the business of insurance. Accordingly, insurers should seek
10 to maintain capital above the RBC levels required by [sections 82 through 94]. Additional capital is
11 used and useful in the insurance business and helps to secure an insurer against various risks inherent
12 in or affecting the business of insurance and not accounted for or only partially measured by the
13 risk-based capital requirements contained in [sections 82 through 94].

14 (5) If a domestic insurer files an RBC report that in the judgment of the commissioner is
15 inaccurate, the commissioner shall adjust the RBC report to correct the inaccuracy and shall notify the
16 insurer of the adjustment. The notice must contain a statement of the reason for the adjustment. An
17 RBC report so adjusted is referred to as an adjusted RBC report.

18
19 **NEW SECTION. Section 85. Company action level event.** (1) "Company action level event"
20 means any of the following events:

21 (a) the filing of an RBC report by an insurer which indicates that:

22 (i) the insurer's total adjusted capital is greater than or equal to its regulatory action level RBC
23 but less than its company action level RBC; or

24 (ii) for a life or disability insurer, the insurer has total adjusted capital that is greater than or
25 equal to its company action level RBC but less than the product of its authorized control level RBC and
26 2.5 and that has a negative trend;

27 (b) the notification by the commissioner to the insurer of an adjusted RBC report that indicates
28 an event in subsection (1)(a) if the insurer does not challenge the adjusted RBC report under [section
29 89] or if the commissioner has rejected the insurer's challenge.

30 (2) In the event of a company action level event, the insurer shall prepare and submit to the

1 commissioner an RBC plan that must:

2 (a) identify the conditions that contribute to the company action level event;

3 (b) contain proposals of corrective actions that the insurer intends to take and that would be
4 expected to result in the elimination of the company action level event;

5 (c) provide projections of the insurer's financial results in the current year and at least the next
6 4 years, both in the absence of proposed corrective actions and giving effect to the proposed corrective
7 actions, including projections of statutory operating income, net income, capital, and surplus. The
8 projections for both new and renewal business may include separate projections for each major line of
9 business and separately identify each significant income, expense, and benefit component.

10 (d) identify the key assumptions impacting the insurer's projections and the sensitivity of the
11 projections to the assumptions; and

12 (e) identify the quality of and problems associated with the insurer's business, including but
13 not limited to its assets, anticipated business growth and associated surplus strain, extraordinary
14 exposure to risk, mix of business, and use of reinsurance, if any, in each case.

15 (3) The RBC plan must be submitted:

16 (a) within 45 days of the company action level event; or

17 (b) if the insurer challenges an adjusted RBC report pursuant to [section 89], within 45 days
18 after notification to the insurer that the commissioner has, after a hearing, rejected the insurer's
19 challenge.

20 (4) Within 60 days after the submission by an insurer of an RBC plan to the commissioner, the
21 commissioner shall notify the insurer as to whether the RBC plan may be implemented or is
22 unsatisfactory in the judgment of the commissioner. If the commissioner determines that the RBC plan
23 is unsatisfactory, the notification to the insurer must set forth the reasons for the determination and
24 may set forth proposed revisions that will render the RBC plan satisfactory in the judgment of the
25 commissioner. Upon notification from the commissioner, the insurer shall prepare a revised RBC plan,
26 which may incorporate by reference any revisions proposed by the commissioner, and shall submit the
27 revised RBC plan to the commissioner:

28 (a) within 45 days after the notification from the commissioner; or

29 (b) if the insurer challenges the notification from the commissioner under [section 89], within
30 45 days after a notification to the insurer that the commissioner has, after a hearing, rejected the

insurer's challenge.

(5) In the event of a notification by the commissioner to an insurer that the insurer's RBC plan or revised RBC plan is unsatisfactory, the commissioner may at the commissioner's discretion, subject to the insurer's right to a hearing under [section 89], specify in the notification that the notification constitutes a regulatory action level event.

(6) Each domestic insurer that files an RBC plan or revised RBC plan with the commissioner shall file a copy of the RBC plan or revised RBC plan with the insurance commissioner in any state in which the insurer is authorized to do business if:

(a) the state has an RBC provision substantially similar to [section 90(1)]; and

(b) the insurance commissioner of that state has notified the insurer in writing of its request for the filing, in which case the insurer shall file a copy of the RBC plan or revised RBC plan in that state by the later of:

(i) 15 days after the receipt of notice to file a copy of its RBC plan or revised RBC plan with that state; or

(ii) the date on which the RBC plan or revised RBC plan is filed under [section 85(3) and (4)].

NEW SECTION. Section 86. Regulatory action level event. (1) "Regulatory action level event" means, with respect to any insurer, any of the following events:

(a) the filing of an RBC report by the insurer that indicates that the insurer's total adjusted capital is greater than or equal to its authorized control level RBC but less than its regulatory action level RBC;

(b) the notification by the commissioner to an insurer of an adjusted RBC report that indicates the event in subsection (1)(a) if the insurer does not challenge the adjusted RBC report under [section 89] or the commissioner rejects the insurer's challenge;

(c) the failure of the insurer to file an RBC report by the filing date, unless the insurer has provided an explanation for the failure that is satisfactory to the commissioner and has cured the failure within 10 days after the filing date;

(d) the failure of the insurer to submit an RBC plan to the commissioner within the time period set forth in [section 85(3)];

(e) notification by the commissioner to the insurer that:

1 (i) the RBC plan or revised RBC plan submitted by the insurer is unsatisfactory in the judgment
2 of the commissioner; and

3 (ii) the notification constitutes a regulatory action level event with respect to the insurer if the
4 insurer has not challenged the determination under [section 89];

5 (f) if, pursuant to [section 89], the insurer challenges a determination by the commissioner, the
6 notification by the commissioner to the insurer that the commissioner has, after a hearing, rejected the
7 challenge;

8 (g) notification by the commissioner to the insurer that the insurer has failed to adhere to its
9 RBC plan or revised RBC plan, but only if the failure has a substantial adverse effect on the ability of
10 the insurer to eliminate the company action level event in accordance with its RBC plan or revised RBC
11 plan and the commissioner has so stated in the notification and if the insurer has not challenged the
12 determination under [section 89] or the commissioner has not rejected the insurer's challenge.

13 (2) In the event of a regulatory action level event, the commissioner shall:

14 (a) require the insurer to prepare and submit an RBC plan or, if applicable, a revised RBC plan;

15 (b) perform an examination or analysis as the commissioner considers necessary of the assets,
16 liabilities, and operations of the insurer including a review of its RBC plan or revised RBC plan; and

17 (c) subsequent to the examination or analysis, issue a corrective order specifying corrective
18 actions that the commissioner determines are required.

19 (3) In determining corrective actions, the commissioner may take into account factors
20 considered relevant with respect to the insurer based upon the commissioner's examination or analysis
21 of the assets, liabilities, and operations of the insurer, including but not limited to the results of any
22 sensitivity tests undertaken pursuant to the RBC instructions. The RBC plan or revised RBC plan must
23 be submitted:

24 (a) within 45 days after the occurrence of the regulatory action level event;

25 (b) if the insurer challenges an adjusted RBC report pursuant to [section 89] and the challenge
26 is not frivolous in the judgment of the commissioner, within 45 days after the notification to the insurer
27 that the commissioner has, after a hearing, rejected the insurer's challenge; or

28 (c) if the insurer challenges a revised RBC plan pursuant to [section 89] and the challenge is
29 not frivolous in the judgment of the commissioner, within 45 days after the notification to the insurer
30 that the commissioner has, after a hearing, rejected the insurer's challenge.

(4) The commissioner may retain actuaries and investment experts and other consultants that may be necessary in the judgment of the commissioner to review the insurer's RBC plan or revised RBC plan, to examine or analyze the assets, liabilities, and operations of the insurer, and to formulate the corrective order with respect to the insurer. The fees, costs, and expenses relating to consultants must be borne by the affected insurer or such other party as directed by the commissioner.

NEW SECTION. Section 87. Authorized control level event. (1) "Authorized control level event" means any of the following events:

(a) the filing of an RBC report by the insurer that indicates that the insurer's total adjusted capital is greater than or equal to its mandatory control level RBC but less than its authorized control level RBC;

(b) the notification by the commissioner to the insurer of an adjusted RBC report that indicates the event in subsection (1)(a) if the insurer does not challenge the adjusted RBC report under [section 89] or the commissioner rejects the insurer's challenge;

(c) the failure of the insurer to respond, in a manner satisfactory to the commissioner, to a corrective order if the insurer has not challenged the corrective order under [section 89]; or

(d) if the insurer has challenged a corrective order under [section 89] and the commissioner has, after a hearing, rejected the challenge or modified the corrective order, the failure of the insurer to respond, in a manner satisfactory to the commissioner, to the corrective order subsequent to rejection or modification by the commissioner.

(2) In the event of an authorized control level event with respect to an insurer, the commissioner shall:

(a) take the actions required under [section 86] regarding an insurer with respect to which a regulatory action level event has occurred; or

(b) if the commissioner considers it to be in the best interests of the policyholders and creditors of the insurer and of the public, take the actions necessary to cause the insurer to be placed under regulatory control under Title 33, chapter 2, part 13. In the event that the commissioner places the insurer under regulatory control, the authorized control level event must be considered sufficient grounds for the commissioner to take action under Title 33, chapter 2, part 13, and the commissioner shall have the rights, powers, and duties with respect to the insurer as are set forth in Title 33, chapter

1 2, part 13. In the event that the commissioner takes an action under this subsection pursuant to an
2 adjusted RBC report, the insurer is entitled to the protections afforded to insurers under the provisions
3 of 33-2-1321 through 33-2-1323 pertaining to summary proceedings.

4
5 **NEW SECTION. Section 88. Mandatory control level event.** (1) "Mandatory control level
6 event" means any of the following events:

7 (a) the filing of an RBC report that indicates that the insurer's total adjusted capital is less than
8 its mandatory control level RBC;

9 (b) notification by the commissioner to the insurer of an adjusted RBC report that indicates the
10 event in subsection (1)(a) if the insurer does not challenge the adjusted RBC report under [section 89]
11 or the commissioner rejects the insurer's challenge.

12 (2) In the event of a mandatory control level event:

13 (a) with respect to a life insurer, the commissioner shall take the actions that are necessary to
14 place the insurer under regulatory control under Title 33, chapter 2, part 13. In that event, the
15 mandatory control level event must be considered sufficient grounds for the commissioner to take
16 action under Title 33, chapter 2, part 13, and the commissioner shall have the rights, powers, and
17 duties with respect to the insurer as are set forth in Title 33, chapter 2, part 13. If the commissioner
18 takes an action pursuant to an adjusted RBC report, the insurer is entitled to the protections of
19 33-2-1321 through 33-2-1323 pertaining to summary proceedings. Notwithstanding any of the
20 foregoing, the commissioner may forego action for up to 90 days after the mandatory control level
21 event if the commissioner finds that there is a reasonable expectation that the mandatory control level
22 event may be eliminated within the 90-day period.

23 (b) with respect to a property and casualty insurer, the commissioner shall take the actions
24 necessary to place the insurer under regulatory control under Title 33, chapter 2, part 13, or, in the
25 case of an insurer that is not writing business and that is running-off its existing business, may allow
26 the insurer to continue its runoff under the supervision of the commissioner. In either event, the
27 mandatory control level event must be considered sufficient grounds for the commissioner to take
28 action under Title 33, chapter 2, part 13, and the commissioner shall have the rights, powers, and
29 duties with respect to the insurer as are set forth in Title 33, chapter 2, part 13. If the commissioner
30 takes an action pursuant to an adjusted RBC report, the insurer is entitled to the protections of

33-2-1321 through 33-2-1323 pertaining to summary proceedings. Notwithstanding any of the foregoing, the commissioner may forego action for up to 90 days after the mandatory control level event if the commissioner finds there is a reasonable expectation that the mandatory control level event may be eliminated within the 90-day period.

NEW SECTION. Section 89. Notification and hearing. (1) An insurer has the right to a hearing before the department upon notification by the commissioner:

(a) of an adjusted RBC report or unsatisfactory RBC plan or revised RBC plan that constitutes a regulatory action level event with respect to the insurer;

(b) that the insurer has failed to adhere to its RBC plan or revised RBC plan and that the failure has a substantial adverse effect on the ability of the insurer to eliminate the company action level event with respect to the insurer in accordance with its RBC plan or revised RBC plan; or

(c) of a corrective order with respect to the insurer.

(2) The insurer shall notify the commissioner of its request for a hearing within 5 days after the notification by the commissioner under subsection (1). Upon receipt of the insurer's request for a hearing, the commissioner shall set a date for the hearing, which may not be less than 10 or more than 30 days after the date of the insurer's request.

NEW SECTION. Section 90. Confidentiality -- prohibition on announcements -- prohibition on use in ratemaking. (1) With respect to a domestic insurer or a foreign insurer, all RBC reports, to the extent the information in the reports is not required to be set forth in a publicly available annual statement schedule, and all RBC plans, including the results or report of any examination or analysis of an insurer performed pursuant to [sections 82 through 94] and any corrective order issued by the commissioner pursuant to the examination or analysis, that are filed with the commissioner constitute information that might be damaging to the insurer if made available to its competitors and must be kept confidential by the commissioner. This information may not be made public and is not subject to subpoena other than by the commissioner and then only for the purpose of enforcement actions taken by the commissioner pursuant to [sections 82 through 94] or any other provision of the insurance laws of this state.

(2) It is the intent of the legislature that the comparison of an insurer's total adjusted capital

1 to any of its RBC levels is a regulatory tool that may indicate the need for possible corrective action
2 with respect to the insurer and that it is not intended as a means to rank insurers generally. Except as
3 otherwise required under the provisions of [sections 92 through 94], the making, publishing,
4 disseminating, circulating, or placing before the public or causing, directly or indirectly to be made,
5 published, disseminated, circulated, or placed before the public, in a newspaper, magazine, or other
6 publication, in the form of a notice, circular, pamphlet, letter, or poster, over any radio or television
7 station, or in any other way, an advertisement, announcement, or statement containing an assertion,
8 representation, or statement with regard to the RBC levels of any insurer or of any component derived
9 in the calculation that is by any insurer, producer, or other person engaged in any manner in the
10 insurance business would be misleading and is prohibited. However, if any materially false statement
11 with respect to the comparison regarding an insurer's total adjusted capital to its RBC levels or an
12 inappropriate comparison of any other amount to the insurer's RBC levels is published in any written
13 publication and the insurer is able to demonstrate to the commissioner, with substantial proof, the
14 falsity of the statement or the inappropriateness, as the case may be, the insurer may publish an
15 announcement in a written publication if the sole purpose of the announcement is to rebut the
16 materially false statement.

17 (3) It is the further intent of the legislature that the RBC instructions, RBC reports, adjusted
18 RBC reports, RBC plans, and revised RBC plans are intended solely for use by the commissioner in
19 monitoring the solvency of insurers and the need for possible corrective action with respect to insurers
20 and may not be used by the commissioner for ratemaking or considered or introduced as evidence in
21 any rate proceeding or used by the commissioner to calculate or derive any elements of an appropriate
22 premium level or rate of return for any line of insurance that an insurer or any affiliate is authorized to
23 write.

24
25 **NEW SECTION. Section 91. Supplemental provisions -- rules -- exemption.** (1) The provisions
26 of [sections 82 through 94] are supplemental to any other provisions of the laws of this state and do
27 not preclude or limit any other powers or duties of the commissioner under the law, including but not
28 limited to Title 33, chapter 2, part 13.

29 (2) The commissioner may adopt reasonable rules necessary for the implementation of [sections
30 82 through 94].

1 (3) The commissioner may exempt from the application of [sections 82 through 94] any
2 domestic property and casualty insurer that:

- 3 (a) writes direct business only in this state;
4 (b) writes direct annual premiums of \$2 million or less; and
5 (c) does not assume reinsurance in excess of 5% of direct premium written.
6

7 **NEW SECTION. Section 92. Foreign insurers.** (1) A foreign insurer shall, upon the written
8 request of the commissioner, submit to the commissioner an RBC report for the previous calendar year
9 on the later of:

10 (a) the date that an RBC report would be required to be filed by a domestic insurer under
11 [section 84]; or

12 (b) 15 days after the request is received by the foreign insurer.

13 (2) A foreign insurer shall, at the written request of the commissioner, promptly submit to the
14 commissioner a copy of any RBC plan that is filed with the insurance commissioner of any other state.

15 (3) In the event of a company action level event, regulatory action level event, or authorized
16 control level event, with respect to any foreign insurer as determined under the RBC statute applicable
17 in the state of domicile of the insurer or, if an RBC statute is not in force in that state, under the
18 provisions of [sections 82 through 94], if the insurance commissioner of the state of domicile of the
19 foreign insurer fails to require the foreign insurer to file an RBC plan in the manner specified under that
20 state's RBC statute or, if an RBC statute is not in force in that state, under [section 85], the
21 commissioner may require the foreign insurer to file an RBC plan with the commissioner. In that event,
22 the failure of the foreign insurer to file an RBC plan with the commissioner is grounds to order the
23 insurer to cease and desist from writing new insurance business in this state.

24 (4) In the event of a mandatory control level event with respect to any foreign insurer, if a
25 domiciliary receiver has not been appointed with respect to the foreign insurer under the rehabilitation
26 and liquidation statute applicable in the state of domicile of the foreign insurer, the commissioner may
27 make application to a district court of this state permitted under 33-2-1380 with respect to the
28 liquidation of property of foreign insurers found in this state, and the occurrence of the mandatory
29 control level event must be considered adequate grounds for the application.
30

1 **NEW SECTION.** **Section 93. Applicability for 1995.** (1) For RBC reports required to be filed
2 by property and casualty insurers with respect to 1995, the following requirements apply in lieu of the
3 provisions of [sections 85 through 88]:

4 (a) In the event of a company action level event with respect to a domestic insurer, the
5 commissioner will not take regulatory action under [sections 82 through 94].

6 (b) In the event of a regulatory action level event under [section 86(1)(a), (1)(b), or (1)(c)], the
7 commissioner shall take the actions required under [section 86(2)].

8 (c) In the event of a regulatory action level event under [section 86(1)(d), (1)(e), (1)(f), or
9 (1)(g)] or an authorized control level event, the commissioner shall take the actions required under
10 [section 86(2) and (3)] with respect to the insurer.

11 (4) In the event of a mandatory control level event with respect to an insurer, the commissioner
12 shall take the actions required under [section 88].

13
14 **NEW SECTION.** **Section 94. Notices.** All notices by the commissioner to an insurer that may
15 result in regulatory action are effective on dispatch if transmitted by certified mail or, in the case of any
16 other transmission, are effective on the insurer's receipt of the notice.

17
18 **NEW SECTION.** **Section 95. Repealer.** Sections 33-30-312 and 33-30-313, MCA, are
19 repealed.

20
21 **NEW SECTION.** **Section 96. Codification instruction.** (1) [Section 75] is intended to be
22 codified as an integral part of Title 33, chapter 15, and the provisions of Title 33, chapter 15, apply
23 to [section 75].

24 (2) [Section 76] is intended to be codified as an integral part of Title 33, chapter 2, part 5, and
25 the provisions of Title 33, chapter 2, part 5, apply to [section 76].

26 (3) [Section 77] is intended to be codified as an integral part of Title 33, chapter 15, part 4,
27 and the provisions of Title 33, chapter 15, part 4, apply to [section 77].

28 (4) [Sections 78 through 81] are intended to be codified as an integral part of Title 33, chapter
29 3, and the provisions of Title 33, chapter 3, apply to [sections 78 through 81].

30 (5) [Sections 82 through 94] are intended to be codified as an integral part of Title 33, chapter

1 2, and the provisions of Title 33, chapter 2, apply to [sections 82 through 94].

2
3 NEW SECTION. **Section 97. Severability.** If a part of [this act] is invalid, all valid parts that
4 are severable from the invalid part remain in effect. If a part of [this act] is invalid in one or more of
5 its applications, the part remains in effect in all valid applications that are severable from the invalid
6 applications.

7 -END-

3/15 COMMITTEE REPORT—BILL CONCURRED
 3/18 2ND READING CONCURRED 46 0
 3/20 3RD READING CONCURRED 48 2

RETURNED TO HOUSE
 3/21 SIGNED BY SPEAKER
 3/22 SIGNED BY PRESIDENT
 3/23 TRANSMITTED TO GOVERNOR
 3/27 SIGNED BY GOVERNOR
 CHAPTER NUMBER 252
 EFFECTIVE DATE: 03/27/95

HB 554 INTRODUCED BY HARPER, ET AL.
 RELATE TO SMALL BREWERIES, HOME BREWING, AND IN-STATE
 BREWERIES

2/14 INTRODUCED
 2/14 FIRST READING
 2/14 REFERRED TO BUSINESS & LABOR
 2/15 FISCAL NOTE REQUESTED
 2/18 FISCAL NOTE RECEIVED
 2/22 FISCAL NOTE PRINTED
 3/01 HEARING
 3/08 COMMITTEE REPORT—BILL PASSED AS AMENDED
 3/11 2ND READING PASSED AS AMENDED 53 42
 3/21 3RD READING FAILED 40 56

HB 555 INTRODUCED BY SOFT
 REVISE LAWS GOVERNING PRACTICES AND PROCEDURES OF
 DIRECT-ENTRY MIDWIVES

2/14 INTRODUCED
 2/14 FIRST READING
 2/14 REFERRED TO HUMAN SERVICES & AGING
 2/15 HEARING
 2/15 TABLED IN COMMITTEE
 2/23 MISSED TRANSMITTAL DEADLINE
 DIED IN COMMITTEE

HB 556 INTRODUCED BY SIMON, ET AL.
 GENERALLY REVISE STATE INSURANCE LAWS
 BY REQUEST OF THE STATE AUDITOR

2/14 INTRODUCED
 2/14 FIRST READING
 2/14 REFERRED TO BUSINESS & LABOR
 2/16 HEARING
 2/16 COMMITTEE REPORT—BILL PASSED
 2/18 2ND READING PASSED 91 7
 2/20 3RD READING PASSED 94 5

TRANSMITTED TO SENATE
 2/21 FIRST READING
 2/21 REFERRED TO BUSINESS & INDUSTRY
 3/01 HEARING
 3/03 COMMITTEE REPORT—BILL CONCURRED AS AMENDED
 3/08 2ND READING CONCURRED AS AMENDED 48 0
 3/09 3RD READING CONCURRED 42 5

RETURNED TO HOUSE WITH AMENDMENTS
 3/30 2ND READING AMENDMENTS CONCURRED 94 2
 3/31 3RD READING AMENDMENTS CONCURRED 85 7
 4/05 SIGNED BY SPEAKER

4/06 SIGNED BY PRESIDENT
 4/07 TRANSMITTED TO GOVERNOR
 4/12 SIGNED BY GOVERNOR
 CHAPTER NUMBER 379
 EFFECTIVE DATE: 04/12/95—SECTIONS 31 & 100
 EFFECTIVE DATE: 10/01/95—SECTIONS 1-30 & 32-99

HB 557 INTRODUCED BY ELLINGSON
 ALLOW DEPARTMENT OF HEALTH AND ENVIRONMENTAL SCIENCES AND
 LOCAL HEALTH BOARDS TO ESTABLISH SANITATION STANDARDS
 REGULATING PRACTICE OF TATTOOING

2/15 INTRODUCED
 2/15 FIRST READING
 2/15 REFERRED TO BUSINESS & LABOR
 2/16 HEARING
 2/16 FISCAL NOTE REQUESTED
 2/16 COMMITTEE REPORT—BILL PASSED AS AMENDED
 2/17 FISCAL NOTE RECEIVED
 2/17 FISCAL NOTE PRINTED
 2/18 2ND READING PASSED 83 16
 2/20 3RD READING PASSED 81 18

TRANSMITTED TO SENATE
 2/21 FIRST READING
 2/21 REFERRED TO PUBLIC HEALTH, WELFARE & SAFETY
 3/13 HEARING
 3/17 COMMITTEE REPORT—BILL CONCURRED
 3/25 2ND READING CONCURRED 48 0
 3/27 3RD READING CONCURRED 42 7

RETURNED TO HOUSE
 3/28 SIGNED BY SPEAKER
 3/28 SIGNED BY PRESIDENT
 3/29 TRANSMITTED TO GOVERNOR
 4/03 SIGNED BY GOVERNOR
 CHAPTER NUMBER 324
 EFFECTIVE DATE: 10/01/95

HB 558 INTRODUCED BY MARTINEZ
 EXEMPT FROM PROPERTY TAXATION CERTAIN OWNER-OCCUPIED
 RESIDENCES OWNED BY ELDERLY PERSONS

2/15 INTRODUCED
 2/15 FIRST READING
 2/15 REFERRED TO TAXATION
 2/16 FISCAL NOTE REQUESTED
 2/27 FISCAL NOTE RECEIVED
 2/27 FISCAL NOTE PRINTED
 3/07 HEARING
 3/17 TABLED IN COMMITTEE
 3/29 MISSED TRANSMITTAL DEADLINE FOR 71ST DAY
 DIED IN COMMITTEE

HB 559 INTRODUCED BY MENAHAN, ET AL.
 EXEMPT PINOCHLE TOURNAMENTS SPONSORED BY NONPROFIT
 ORGANIZATIONS FROM CERTAIN PROVISIONS OF CARD GAMES LAWS

2/15 INTRODUCED
 2/15 FIRST READING
 2/15 REFERRED TO BUSINESS & LABOR
 2/16 HEARING
 2/16 COMMITTEE REPORT—BILL PASSED AS AMENDED

HOUSE BUSINESS & LABOR

Page 8

- BILL NO - REFERRED - HEARING - OTHER CONSIDERATION DATES - EXECUTIVE ACTION/DATE/VOTE -----
 -- REREFERRED ----- DATE READ

HB0536	MILLS, NORM		REVISE OUT-OF-STATE MAIL SERVICE PHARMACY LAWS				
	2/11	2/14	PASS AS AMENDED	VOTE:			2/15
HB0537	LARSON, DON		PREVENT STACKING OF PREMISES WITH COMMON INTERESTS & VIDEO GAMING MACHINES				
	2/11	2/14	PASS AS AMENDED	2/14	VOTE: 17-1		2/15
HB0549	SHEA, DEBBIE		REVISE APPLICATION FOR OFF-PREMISES RETAIL BEER AND WINE LICENSE				
	2/14	2/16	PASS AS AMENDED	2/16	VOTE: 18-0		2/16
HB0554	HARPER, HAL		SMALL BREWERY RETAIL BEER SALES -- HOME BREWING				
	2/14	3/01	PASS AS AMENDED	3/8	VOTE: 18-8		3/08
HB0556	SIMON, BRUCE		GENERAL REVISION OF INSURANCE LAW				
	2/14	2/16	DO PASS	2/16	VOTE: 18-0		2/16
HB0557	ELLINGSON, JON		ALLOW DHES & LOCAL HEALTH BOARDS TO ADOPT STANDARDS REGULATING TATTOOING				
	2/15	2/16	PASS AS AMENDED	2/16	VOTE: 18-0		2/16
HB0559	MENAHAN, RED		EXEMPT PINOCHLE TOURNAMENTS RUN BY NONPROFIT ORG. FROM CERTAIN GAMBLING LAWS				
	2/15	2/16	PASS AS AMENDED	2/16	VOTE: 18-0		2/16
HB0567	HIBBARD, CHASE		REVISE QUALIFIED MONTANA SMALL BUSINESS INVESTMENT CAPITAL COMPANY POLICY				
	2/16	3/01	PASS AS AMENDED	3/1	VOTE: 18-0	TAXATION	3/02
HB0574	REHBEIN, WILLIAM		PRIVATIZE STATE LIQUOR STORES TO FRANCHISE LIQUOR STORES				
	2/28	3/02	PASS AS AMENDED	3/7	VOTE: 12/6		3/07
HB0580	OHS, KARL		ACCOMODATION TAX REVENUE BOND ISSUE AND GRANTS FOR TOURISM PROJECTS				
	3/16	3/20	TABLED ON	3/21	VOTE: 11-7		
HB0581	FORBES, ROSE		FUNDING FOR TOURISM FACILITIES				
	3/16	3/20	TABLED ON	3/21	VOTE: 10-8		
	MERCER, JOHN		RESEARCH AND DEVELOPMENT AND INFRASTRUCTURE INVESTMENT				

MINUTES

MONTANA HOUSE OF REPRESENTATIVES 54th LEGISLATURE - REGULAR SESSION

COMMITTEE ON BUSINESS & LABOR

Call to Order: By CHAIRMAN BRUCE T. SIMON, on February 16, 1995,
at 8:00 AM.

ROLL CALL

Members Present:

Rep. Bruce T. Simon, Chairman (R)
Rep. Norm Mills, Vice Chairman (Majority) (R)
Rep. Robert J. "Bob" Pavlovich, Vice Chairman (Minority) (D)
Rep. Vicki Cocchiarella (D)
Rep. Charles R. Devaney (R)
Rep. Jon Ellingson (D)
Rep. Alvin A. Ellis, Jr. (R)
Rep. David Ewer (D)
Rep. Rose Forbes (R)
Rep. Jack R. Herron (R)
Rep. Bob Keenan (R)
Rep. Don Larson (D)
Rep. Rod Marshall (R)
Rep. Jeanette S. McKee (R)
Rep. Karl Ohs (R)
Rep. Paul Sliter (R)
Rep. Carley Tuss (D)
Rep. Joe Barnett (R)

Members Excused: None.

Members Absent: None.

Staff Present: Stephen Maly, Legislative Council
Alberta Strachan, Committee Secretary

Please Note: These are summary minutes. Testimony and
discussion are paraphrased and condensed.

Committee Business Summary:

Hearing: HB 549, HB 559, HB 557, HB 556
Executive Action: HB 549, HB 557, HB 556, HB 518, HB 487
HB 458 Remove from Table

HEARING ON HB 549

Opening Statement by Sponsor:

REP. DEBBIE SHEA, HD 35, Silver Bow County stated this bill was
an act revising the laws relating to retail beer and table wine

EXECUTIVE ACTION ON HB 557

Motion: REP. ELLINGSON MOVED HB 557 DO PASS. REP. ELLINGSON MOVED THE AMENDMENTS.

Discussion:

REP. ELLINGSON explained the amendments.

Motion: REP. ELLIS MOVED THE ELLIS AMENDMENTS.

Vote: Motion carried to adopt the Ellis amendment 18-0. Motion to adopt the Ellingson amendment carried 18-0.

Motion/Vote: REP. ELLINGSON MOVED ON HB 557 DO PASS AS AMENDED. Motion carried 18-0.

CHAIRMAN SIMON relinquished the chair to VICE CHAIRMAN MILLS.

HEARING ON HB 556

Opening Statement by Sponsor:

REP. BRUCE SIMON, HD 18, Yellowstone County stated this bill was an act generally revising state insurance law and providing for the disclosure of material transactions and creating a Risk-based Capital for Insurers Act.

Proponents' Testimony:

Frank Coty, Deputy Insurance Commissioner, provided the insurance code amendments summary from the State Auditor's Office, Department of Insurance and the National Association of Insurance Commissioners financial regulation standards and accreditation program. EXHIBITS 2 and 3

Larry Akey, Montana Association of Life Underwriters and the National Association of Independent Insurers said this bill is a clean up bill. The Insurance Commissioner's office has been very willing to work with people in the industry to make certain the language is acceptable.

Jacqueline Lenmark, American Insurance Association, stated she supported the bill.

Ward Shanahan, Farmers Insurance Group, said they supported the bill.

Tom Hopgood, Health Insurance Association of America, also supported the bill.

Roger McGlenn, Executive Director, Independent Insurance Agency of Montana, supported this bill.

Debby Berney, Professional Insurance Agents of Montana, said they supported the bill.

Denny Moreen, American Counsel of Life Insurance, supported the bill.

Tanya Ask, Blue Cross/Blue Shield of Montana, supported the bill.

Greg VanHorssen, State Farm Insurance Company, stated they supported the bill.

Opponents' Testimony:

None.

Questions From Committee Members and Responses:

REP. EWER questioned the meaning of seasoned corporate bonds. Mr. Coty said this is a securities term which is the yield on bonds.

Closing by Sponsor:

The sponsor closed.

EXECUTIVE ACTION ON HB 556

Motion/Vote: REP. SIMON MOVED HB 556 DO PASS. Motion carried 18-0.

EXECUTIVE ACTION ON HB 518

Motion: REP. TUSS MOVED HB 518 DO PASS. REP. TUSS MOVED THE AMENDMENTS.

Vote: Motion to adopt the amendments carried 18-0.

Motion/Vote: REP. TUSS MOVED HB 518 DO PASS AS AMENDED. Motion carried 18-0 on HB 518.

VICE CHAIRMAN MILLS relinquished the chair to CHAIRMAN SIMON.

EXECUTIVE ACTION ON HB 487

Motion: REP. SLITER MOVED HB 487 DO NOT PASS. REP. PAVLOVICH MADE A SUBSTITUTE MOTION ON HB 487 DO PASS.

HOUSE OF REPRESENTATIVES

Business and Labor

ROLL CALL

DATE 2-16-95

NAME	PRESENT	ABSENT	EXCUSED
Rep. Bruce Simon, Chairman	X		
Rep. Norm Mills, Vice Chairman, Majority	X		
Rep. Bob Pavlovich, Vice Chairman, Minority	X		
Rep. Joe Barnett	X		
Rep. Vicki Cocchiarella	X		
Rep. Charles Devaney	X		
Rep. Jon Ellingson	X		
Rep. Alvin Ellis, Jr.	X		
Rep. David Ewer	X		
Rep. Rose Forbes	X		
Rep. Jack Herron	X		
Rep. Bob Keenan	X		
Rep. Don Larson	X		
Rep. Rod Marshall	X		
Rep. Jeanette McKee	X		
Rep. Karl Ohs	X		
Rep. Paul Sliter	X		
Rep. Carley Tuss	X		



HOUSE STANDING COMMITTEE REPORT

February 16, 1995

Page 1 of 1

Mr. Speaker: We, the committee on **Business and Labor** report that **House Bill 556** (first reading copy -- white) do pass.

Signed: _____


Bruce Simon, Chair

Mr

2/16

Committee Vote:

Yes *16*, No *0*.

401259SC.Hbk

HOUSE OF REPRESENTATIVES
VISITORS REGISTER

Business & Labor

DATE 2-16-95

BILL NO. 556 SPONSOR(S) _____

PLEASE PRINT

PLEASE PRINT

PLEASE PRINT

NAME AND ADDRESS	REPRESENTING	Support	Oppose
WARD STANARD HAW	FARMERS INSURANCE	✓	
Debbie Bernvey	PIA - Prot. INS. AGTS of MT	✓	
WARRY AILEY	MT ASSOC OF LIFE UNDERWRITERS	✓	
Roger McHenry	INDEPENDENT INS.	✓	
Frank Cote	AGENTS ASSOC. of MT	✓	
Greg Van Hornes	ST. AUGUSTINE	✓	
Jacqueline Lemark	State Farm Ins. Co		Conditional ✓
Danny Moreen	Am. Ins. Ass'n		✓
Tanya Aik	ACLI	✓	
Ed Grube	Blue Cross Blue Shield	✓	
Tom Horsad	MMBP	✓	
	HIAA	✓	

PLEASE LEAVE PREPARED TESTIMONY WITH SECRETARY. WITNESS STATEMENT FORMS ARE AVAILABLE IF YOU CARE TO SUBMIT WRITTEN TESTIMONY.

STATE AUDITOR
STATE OF MONTANA

EXHIBIT 2
DATE 2-16-95
HB 556

Mark O'Keefe
STATE AUDITOR



COMMISSIONER OF INSURANCE
COMMISSIONER OF SECURITIES

State Auditor's Officer
Department of Insurance
Insurance Code Amendments Summary
2/16/95

This summary includes explanations for substantive revisions to the Montana Insurance Code and the new acts required under accreditation standards established by the National Association of Insurance Commissioners. This summary will not address amendments merely providing for better language usage or language changes resulting from Legislative Council language rules.

Section 1.

2-6-109(5) - permits the Commissioner to send a list of those required to take continuing education to continuing education providers. This act will increase course availability and opportunity for producers and consultants.

Sections 2 & 3.

33-1-207, 208 - clarifies the definitions of disability and life insurance by including credit life and credit disability and reference to indemnification.

Section 4.

33-1-209(1) & (2) - replaces the currently inadequate definition of marine insurance with a more comprehensive definition currently used in other states.

Section 5.

33-1-311(1) & (2) - because the commissioner has duties regarding enforcement of the licensing of motor club representatives and law enforcement agency laws which are not placed in the Insurance Code, further clarification of the scope of the commissioner's duties is required.

Section 6.

33-1-501(1)(b) - permits waiver of insurance form approval requirement and prevents unnecessary duplication of form approval efforts by the Montana Department of Insurance and a department of another state with laws substantially similar to Montana's.

33-1-501(7) - clarifies that group certificate approval is contingent upon conformity with Montana law where the certificates are subject to Montana regulatory and legal jurisdiction.

Section 7.

33-2-117(1) - amends the date by which insurers must pay the certificate of authority continuation fee to conform to the date that other fees are due.

Section 8.

33-2-301(3)(d) - lines, not kinds, of insurance are sold. The definition elimination reflects industry verbiage and usage in other parts of the code.

Section 9.

33-2-302 - affords freer consumer access to lines of insurance not sold by authorized insurers in the state of Montana and prevents renewal where the line has become available through a Montana authorized insurer.

Section 10.

33-2-305(1) & (5) - operates in tandem with 33-2-302 to pull down licensing barriers to purchase of insurance lines not available through a Montana authorized insurer.

Section 11.

33-2-307(1)(b)(i)(B) - brings the capital and surplus thresholds in compliance with NAIC recommendations.

33-2-307(1)(b)(ii) - a technical change which better reflects Lloyd's structural changes and acceptance of corporate members, as well as individual unincorporated members.

Section 12.

33-2-501(11) - removes the dollar limitations of the admissibility of electronic data processing equipment and reduces the permissible useful life for EDP equipment. Given the rapid advancements in the computer field, 8 years is a more conservative and realistic period for depreciation of EDP equipment.

Page 3
February 15, 1995

Sections 13 - 18, and Section 76.

33-2-521 through 33-2-529, and New Section entitled "Reserve calculation -- indeterminate premium plan -- minimum standards for disability" - Under NAIC accreditation standards, these changes to the Standard Valuation law must be in place by 1/1/96.

Section 19.

33-2-531(1) & (2) - eliminates wasteful paperwork for insurers currently required to put policy loans on deposit.

Section 20.

33-2-701(2) - reduces paperwork and under NAIC accreditation standards, annual and quarterly diskette filings are required by 1/1/96.

Section 21.

33-2-705(6) - the interest rate on unpaid taxes mentioned in 31-1-107 suggests that it must be determined by mutual agreement between the Department and the offending insurer. This practice is problematic and the rate should be set at a more sensible rate.

Section 22.

33-2-708(1)(k) - clarifies licensing fees required of motor club representatives, over which the insurance commissioner has licensing authority pursuant to 61-12-302.

33-2-708(1)(n)(iii) - clarifies that forms submitted must relate to the same policy and prevents insurers from submitting forms together which should be considered separately from one another.

Section 23.

33-2-803(1) - operates in tandem with 33-2-820 to permit insurers to invest in non-dividend paying stocks, which would be a prohibited practice without the amendments. The prohibition is not practical.

Section 24.

33-2-806(6) - raises, upon insurer request, the permissible investment in common stock from 10% of insurer assets to 15%. The department has determined this adjustment to be fiscally

sound.

Section 25.

33-2-820 - see Section 23 comments.

Section 26.

33-2-1111(2)(c)(v) - important for NAIC accreditation standards. The deleted phrase in (2)(c)(v) exempts important registration information from filing.

Section 27.

33-2-1201(6) - the exception for sprinklered risks has no merit and should be removed.

Section 28.

33-2-1216(5)(b)(iii) - see Section 11, 33-2-307(1)(b)(ii) comments.

Section 29.

33-2-1217(3)(4) - provides a definition for the term "qualified United States financial institution" as used in the section. The definition also meets NAIC accreditation recommendations.

Section 30.

33-2-1218 - corrects a 1993 bill drafting error which effectively restricted the law to very old or already cancelled reinsurance agreements. The law should apply to agreements in effect now.

Section 31.

33-2-1510(8) & (10) - clarifies required provisions for controlling producer / controlled insurer agreements by including language which was inadvertently omitted last session.

Section 32.

33-2-1605(4) - corrects a typographical error in the 1993 law.

Section 33.

33-3-431 - eliminates the differentiation between stock and mutual insurers, each of whom require as much oversight as the

Page 5
February 15, 1995

other. Also, the amendments clarify the commissioner approval requirement for repayment of either principle or interest on borrowed surplus. Repayment of interest without oversight may jeopardize an insurer's financial condition.

Section 34.

33-4-202 - currently, the approved farm mutual's articles are filed with the Department, the Secretary of State, the insurer and the insurer's local county clerk. Filing with the county clerk is unnecessary.

Section 35.

33-4-203 - eliminates the unnecessary and superfluous review of a farm mutual's articles by the attorney general.

Section 36.

33-5-401(1)(b) - establishes an appropriate distinction between required surplus funds for domestic reciprocals transacting casualty insurance with and without authority for worker's compensation.

Section 37.

33-7-117 - extends application of new sections embodying the Disclosure of Material Transactions Act to Fraternal Benefit Societies.

Section 38.

33-10-201 - under NAIC accreditation standards, the Life and Health Insurance Guaranty Association Act must be modified in this manner by 1/1/96. The modifications clarify the application provisions of the act.

Section 39.

33-10-202(6) - clarifies the definition of "member insurer" and conforms the act to NAIC accreditation standards.

Section 40.

33-11-102(1) - provides a definition for "completed operations liability" as used in Chapter 11, in conformity with NAIC accreditation standards.

Section 41.

33-11-104(13) - provides a penalty for risk retention groups operating in violation of Montana law. The penalty provision is required by NAIC accreditation standards.

Section 42.

33-11-108(1)(g) - biographical information is needed to ensure that the interests of the membership of the purchasing groups not compromised by controlling members with contradictory interests.

Section 43.

33-14-304(2) - eliminates a reference to "brokers" which is a term not recognized in the Montana Insurance Code.

Section 44.

33-15-301 - clarifies the intended effect of standard provisions requirements as including contract language (provisions) and contract obligations (benefits) in all contracts of insurance (policies and certificates).

Section 45.

33-15-303(3) - creates uniform standards for form designating numbers and revision dates. Currently, this provision is found in the disability chapter, but should apply to insurance forms generally.

Section 46.

33-16-202(1) - eliminates rule promulgation mandate in an area where regulation by rule is not essential.

Section 47.

33-16-235(1) - similar to 33-16-202, this deregulatory amendment eliminates rule and reporting mandates where existing regulatory tools are sufficient.

Section 48.

33-17-102(1)(d) - clarifies the definition of "adjuster" to include licensed third party administrators.

33-17-102(9)(a)(ii) - creates uniformity for the "managing

Page 7
February 15, 1995

general agent" definition throughout the insurance code. This definition conflicted with the one found at 33-2-501.

Section 49.

33-17-211(1)(d) & (e) - limits the time period allowed between examination passage and license applications so that applicants may not use stale tests as basis for licensing. The amendment also clarifies that licenses issued based on Montana residency terminate upon relocation to another state.

Section 50.

33-17-405 - clarifies the commissioner's status as agent for the nonresident person for service of process purposes.

Section 51 & 52.

33-17-503 & 33-17-603 - clarifies that consultant and administrator's application fees, respectively, are to be deposited with the general fund. The amendments also eliminate the need to physically prepare a new license each year for each consultant by establishing continuing licenses.

Section 53.

33-17-1001(2) - permits revocation, suspension, refusal or denial of an insurance agency license where a partner or officer, whether or not a licensed producer, is engaged in prohibited conduct which is injurious to the public's interest.

Section 54.

This section was erroneously included in this bill. No substantive change was made.

Section 55.

33-18-301(3) - establishes policyholder protection standards for funeral insurance policy solicitation and sales.

Section 56 & 57.

33-22-131(1) & (4), 33-22-132(1) & (4) - prevents some mandated benefits from appearing in policies in which it does not make sense to include them (i.e., mammography benefits in accident only policies, phenylketonuria benefits in dental policies, etc.).

Section 58.

33-22-201(6) - eliminates erroneous reference to sections of law which do not exist and prevents inadvertent application of sections later enacted in those reserved sections.

33-22-201(7) - section is taken out of disability chapter and is placed more appropriately in contracts chapter of code (see Section 45), providing for uniformity of all insurance forms, not just disability forms.

Section 59.

33-22-202(3) - eliminates erroneous reference to sections of code which do not exist and prevents inadvertent application of sections later enacted in those reserved sections.

Section 60.

33-22-301 - allows insurers to collect a premium for a new insured (i.e., converting coverage to family coverage in the case of a first born child). The amendment also allows an insurer to require notification of a new insured on a policy.

Section 61.

33-22-303(1) - clarifies that the well-child care benefit provision applies to medical expense disability policies and not disability income policies.

Section 62.

33-22-504(1) & (2) - eliminates distinction between individuals with prior family coverage and those without, and permits newborns of both classes to obtain coverage after birth.

33-22-504(4) - prevents inclusion of newborn coverage in policies in which inclusion is erroneous.

33-22-504(5) - clarifies which policies are required to conform to this provision.

33-22-504(6) - allows insurers to collect a premium for a new insured (i.e., converting coverage to family coverage in the case of a first born child). The amendment also allows an insurer to require notification of a new insured on a policy.

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February 15, 1995

Section 63.

33-22-508(1) - applies the conversion on termination of eligibility to policies and certificates alike.

Section 64.

33-22-1120(1) - similar to Section 63, the amendment applies Montana long term care policy laws to policies or certificates issued to Montana residents.

Section 65.

33-22-1803(16)(a) - clarifies criteria for consideration of a person as a late enrollee.

33-22-1803(8) - clarifies that gender may not be considered as a case characteristic in determination of rates, pursuant to the unisex insurance law.

Section 66.

33-22-1819(13) - clarifies that monies paid to the small employer carrier reinsurance program are not general fund monies, but monies to be used for the program's obligations.

Section 67.

33-30-102(1) - eliminates erroneous reference to portions of the licensing chapter which are not relevant to health service corporations. Also, the amendments apply the Disclosure of Material Transactions Act to health service corporations.

Section 68.

33-30-107 - reduces paperwork and under NAIC accreditation standards, annual and quarterly diskette filing pursuant to these standards is required by 1/1/96.

Section 69.

33-30-108(3) - clarifies when health service corporation license fees are due.

Section 70.

33-30-202 - eliminates the unnecessary requirement of a health service corporation's annual report. Given the required annual

and quarterly statements, the requirement is redundant.

Section 71.

33-30-204(1)(a) - eliminates unnecessary provisions in light of the amendment to 33-30-311.

Section 72.

33-30-311 - subjects insurance producers for health service corporation to the part of the code regulating insurance producers.

Section 73.

allows insurers to collect a premium for a new insured (i.e., converting coverage to family coverage in the case of a first born child). The amendment also allows an insurer to require notification of a new insured on a policy.

Section 74.

33-31-311(1)(a) - eliminates reference to sections repealed in this bill.

33-31-311(5) - subjects health maintenance organizations to the Material Transactions Disclosure Act (Sections 78 - 81).

Section 75.

Right to return policy - removes section from the disability insurance portion of the bill, includes life insurance free look period, and places section in chapter covering insurance contracts in the insurance code.

Section 76.

See Section 13 comments.

Section 77.

Dating insurance applications - prevents fraudulent collection of insurance benefits for period where insured was not actually covered. Acknowledgement of the purpose of the section prevents application to life insurance contracts where backdating is an acceptable, common industry practice.

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February 15, 1995

Sections 78 - 81.

Disclosure of Material Transactions Act - under NAIC accreditation standards, this act must be in place by 1/1/97. Generally speaking, the act requires reporting by insurers of significant transactions and events concerning material acquisitions and dispositions of assets, and non-renewals, cancellations, or revisions of ceded reinsurance agreements. The reporting allows regulators to survey insurers' solvency status and is an important component of financial oversight, as well as policyholder and industry protection.

Sections 82 - 94.

Risk Based Capital for Insurers Act - under NAIC accreditation standards, this act must be in place by 1/1/97. Current regulations require a flat surplus minimum for different classes of insurers. The RBC Act tailors each insurer's required surplus to a more realistic amount according to a formula. The surplus minimum is adjusted for each insurer by application of formula factors relevant to the particular insurer. The Act also provides for administrative hearings for insurers disputing the commissioner's determinations under the Act.

Section 95.

Repeals sections 33-30-312 and 33-30-313, both of which are unnecessary after amendments to 33-30-311.

EXHIBIT 3
DATE 2-16-95
HB 556

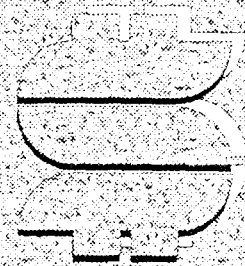
December 1994

NAIC

*National
Association of
Insurance
Commissioners*

The original of this document is stored at the Historical Society at 225 North Roberts Street, Helena, MT 59620-1201. The phone number is 444-2694.

Financial Regulation Standards and Accreditation Program



SENATE BUSINESS & INDUSTRY

- BILL NO - REFERRED - HEARING - OTHER CONSIDERATION DATES - EXECUTIVE ACTION/DATE/VOTE - REREFERRED - DATE READ									
HB0533	ARNOTT, PEGGY			PORTABILITY OF INSURANCE AND PREMIUM INCREASE DISTRIBUTION				VOTE:	JC/HEALTH CARE
	2/27								
HB0536	MILLS, NORM			REVISE OUT-OF-STATE MAIL SERVICE PHARMACY LAWS					
	2/21	3/14		CONCUR	3/14	VOTE: UNAN			3/15
HB0537	LARSON, DON			PREVENT STACKING OF PREMISES WITH COMMON INTERESTS & VIDEO GAMING MACHINES					
	2/21	3/03		CONCUR AS AMENDED	3/09	VOTE: 8-1			3/17
HB0543	WAGNER, DOUGLAS			REVISE SECURITY FOR SEEKING INJUNCTION OR RESTRAINING ORDER					
	2/21	3/14		CONCUR AS AMENDED	3/16	VOTE: 7-2			3/17
HB0549	SHEA, DEBBIE			REVISE APPLICATION FOR OFF-PREMISES RETAIL BEER AND WINE LICENSE					
	2/21	3/08		CONCUR	3/08	VOTE: UNAN			3/09
HB0556	SIMON, BRUCE			GENERAL REVISION OF INSURANCE LAW					
	2/21	3/01		CONCUR AS AMENDED	3/02	VOTE: 7-1			3/03
HB0559	MENAHAN, RED			EXEMPT PINOCHLE TOURNAMENTS RUN BY NONPROFIT ORG. FROM CERTAIN GAMBLING LAWS					
	2/27	3/03		CONCUR	3/03	VOTE: UNAN			3/04
HB0574	REHBEIN, WILLIAM			PRIVATIZE STATE LIQUOR STORES TO FRANCHISE LIQUOR STORES					
	3/15	3/21		CONCUR AS AMENDED	3/22	VOTE: 6-3			3/23
HB0593	DENNY, MATT			REVISE PUBLIC SERVICE COMMISSION					
	3/27	3/30		TABLED ON	03/30	VOTE: 5-4			
HB0602	KITZENBERG, SAM			INFRASTRUCTURE LOANS FOR JOB CREATION					
	3/24	3/27		CONCUR AS AMENDED	3/27	VOTE: UNAN			3/28
SB0011	KLAMPE, TERRY			GEN REVISE VETERINARY MEDICINE LAW; EXEMPT CERTAIN PERSONS FROM LICENSURE					
	1/03	1/11		PASS AS AMENDED	1/12	VOTE: UNAN	AGRICULTURE		1/12
SB0012	TOEWS, DARYL			ALLOW BD OF REALTY TO IMPOSE ADMINISTRATIVE FINES ON LICENSEES					
	1/02	1/10		TABLED ON	01/12	VOTE: UNAN			

MINUTES

MONTANA SENATE
54th LEGISLATURE - REGULAR SESSION

COMMITTEE ON BUSINESS & INDUSTRY

Call to Order: By CHAIRMAN JOHN HERTEL, on March 1, 1995, at
8:00 a.m.

ROLL CALL

Members Present:

Sen. John R. Hertel, Chairman (R)
Sen. Steve Benedict, Vice Chairman (R)
Sen. William S. Crismore (R)
Sen. C.A. Casey Emerson (R)
Sen. Ken Miller (R)
Sen. Mike Sprague (R)
Sen. Gary Forrester (D)
Sen. Terry Klampe (D)
Sen. Bill Wilson (D)

Members Excused: N/A

Members Absent: N/A

Staff Present: Bart Campbell, Legislative Council
Lynette Lavin, Committee Secretary

Please Note: These are summary minutes. Testimony and
discussion are paraphrased and condensed.

Committee Business Summary:

Hearing: HB 556, HB 310, HB 336
Executive Action: HB 310 BE CONCURRED IN
HB 207 TABLED

HEARING ON HB 556

Opening Statement by Sponsor:

REP. BRUCE SIMON, HD 18, Billings, explained the purpose of HB 556 was to bring the Montana Code up to date. He stated there were a number of changes. He said the bill had been thoroughly reviewed by the affected parties and they were all here to testify as proponents. He reported basically, the language had to be brought into conformance with modern language; some eliminations were made of unnecessary burden on the insurance business that no longer were appropriate. He stated most importantly, changes were made to allow the accreditation of the

State Auditor's Office. He maintained this was extremely important, not only to the office itself, but to the domestic carriers that were domiciled here in Montana. **REP. SIMON** said without that accreditation, they must go through a lot to sell products outside the borders of Montana and accreditation allowed them to sell outside Montana.

Proponents' Testimony:

Frank Cote, Deputy Insurance Commissioner, State Auditor's Office, related he was in support of HB 556. He presented an 11 page printout of the Insurance Code Amendments Summary, **EXHIBIT #1**. He also presented to the committee a report from the National Association of Insurance Commissioners, **EXHIBIT #2**.

Jacqueline Lenmark, American Insurance Association (AIA), stated they supported HB 556. They did think there was one amendment necessary on the bill and had discussed it with **Mr. Cote** yesterday. She said he agreed, but they would defer to **Bart Campbell, Legislative Council**, for his advice on that matter. She thought section 47 of the bill was contained in SB 196 which had already passed in this committee, through the Senate and through the House and should be repealed if SB 196 was signed by the Governor and it was on the way to the Governor's desk. She declared the amendment they thought may be necessary was a coordination section at the end of the bill that stated, if SB 196 passed, this section was void.

Tayna Ask, Blue Cross and Blue Shield of Montana, told the committee they were in support of HB 556. Today, she also spoke on behalf of **Tom Hopgood, Health Insurance Association of America (HIAA)**, commercial insurers who were supporting this bill. On behalf of BC&BS, she raised the question on Page 87, section 70, which had to do with filing an annual report by health service corporations, of which there were two in the State of Montana. She said this particular section of law was applicable to health service corporations before they also had to file the form 13, which was an annual report of full detail financial report that each insurance company must file with the insurance department on an annual basis. She remarked prior to that law, there was a provision that they had to file something separate. She asserted they were questioning why they must file the separate form when they were brought under the traditional form 13 filing.

Denny Moreen, American Council of Life Insurance, which was a national association of insurance companies, declared they were here in support of this bill. They had a couple minor amendments to propose, which he had discussed with Mr. Cote and the staff. He presented those to **Mr. Campbell**.

Ron Ashabraner, State Farm Insurance Companies, stated they were in support of HB 556.

Opponents' Testimony: None.

Questions From Committee Members and Responses:

SEN. STEVE BENEDICT asked Frank Cote if any of those proponents made an appearance before the House. Mr. Cote stated all of those proponents showed up in the House. He thought SEN. BENEDICT was referring to the amendments and stated they had a mutual agreement, since they were at the final day of the House hearing, so they agreed to leave all the amendments until they arrived at the Senate. Mr. Cote apologized to the committee.

SEN. MIKE SPRAGUE questioned Mr. Cote on what was the purpose of such a large document. Mr. Cote said the purpose of this bill was two-fold; one was basically housekeeping and the other change dealt with accreditation standards, which were substantial, but needed if they were to retain their accreditation in the State of Montana.

Closing by Sponsor:

REP. SIMON closed with an apology to Mr. Campbell and the committee for not sending over a clean bill; however, it came out of drafting so late that it was heard the last day. They were unable to get the bill out any sooner. He thought the amendments were technical in nature and would not have a significant change on the bill.

REP. SIMON asked SEN. BENEDICT to carry HB 556 on the Senate floor.

HEARING ON HB 310Opening Statement by Sponsor:

REP. JOE BARNETT, HD 32, Belgrade, presented HB 310 at the request of Montana Power Company, primarily. He stated the method by which the Montana Consumer Counsel's tax could be refunded would be on the same basis as the Public Service Commission's tax was refunded. He reported the heart of the bill was found on page 2, lines 17 through 21. He asked the committee to listen to Tom Matosich to further clarify HB 310.

Proponents' Testimony:

Tom Matosich, Director of Utility Costs, Montana Power Company read his written testimony, EXHIBIT #3.

John Alke, Montana Dakota Utilities, stated they supported HB 310, in the case of the PSC tax because it was collected currently, their natural gas and electric rates both reflected the current PSC tax rate. He alleged because the MCC tax was not reflected currently, the only change was when they had a rate

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STATE AUDITOR
STATE OF MONTANA

SENATE BUSINESS & INDUSTRY

EXHIBIT NO. 1

DATE 3-1-95

BILL NO. HB 556

Presented by Frank Cote

COMMISSIONER OF INSURANCE
COMMISSIONER OF SECURITIES

Mark O'Keefe
STATE AUDITOR



State Auditor's Officer
Department of Insurance
Insurance Code Amendments Summary
2/16/95

This summary includes explanations for substantive revisions to the Montana Insurance Code and the new acts required under accreditation standards established by the National Association of Insurance Commissioners. This summary will not address amendments merely providing for better language usage or language changes resulting from Legislative Council language rules.

Section 1.

2-6-109(5) - permits the Commissioner to send a list of those required to take continuing education to continuing education providers. This act will increase course availability and opportunity for producers and consultants.

Sections 2 & 3.

33-1-207, 208 - clarifies the definitions of disability and life insurance by including credit life and credit disability and reference to indemnification.

Section 4.

33-1-209(1) & (2) - replaces the currently inadequate definition of marine insurance with a more comprehensive definition currently used in other states.

Section 5.

33-1-311(1) & (2) - because the commissioner has duties regarding enforcement of the licensing of motor club representatives and law enforcement agency laws which are not placed in the Insurance Code, further clarification of the scope of the commissioner's duties is required.

Section 6.

33-1-501(1)(b) - permits waiver of insurance form approval requirement and prevents unnecessary duplication of form approval efforts by the Montana Department of Insurance and a department of another state with laws substantially similar to Montana's.

33-1-501(7) - clarifies that group certificate approval is contingent upon conformity with Montana law where the certificates are subject to Montana regulatory and legal jurisdiction.

Section 7.

33-2-117(1) - amends the date by which insurers must pay the certificate of authority continuation fee to conform to the date that other fees are due.

Section 8.

33-2-301(3)(d) - lines, not kinds, of insurance are sold. The definition elimination reflects industry verbiage and usage in other parts of the code.

Section 9.

33-2-302 - affords freer consumer access to lines of insurance not sold by authorized insurers in the state of Montana and prevents renewal where the line has become available through a Montana authorized insurer.

Section 10.

33-2-305(1) & (5) - operates in tandem with 33-2-302 to pull down licensing barriers to purchase of insurance lines not available through a Montana authorized insurer.

Section 11.

33-2-307(1)(b)(i)(B) - brings the capital and surplus thresholds in compliance with NAIC recommendations.

33-2-307(1)(b)(ii) - a technical change which better reflects Lloyd's structural changes and acceptance of corporate members, as well as individual unincorporated members.

Section 12.

33-2-501(11) - removes the dollar limitations of the admissibility of electronic data processing equipment and reduces the permissible useful life for EDP equipment. Given the rapid advancements in the computer field, 8 years is a more conservative and realistic period for depreciation of EDP equipment.

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Sections 13 - 18, and Section 76.

33-2-521 through 33-2-529, and New Section entitled "Reserve calculation -- indeterminate premium plan -- minimum standards for disability" - Under NAIC accreditation standards, these changes to the Standard Valuation law must be in place by 1/1/96.

Section 19.

33-2-531(1) & (2) - eliminates wasteful paperwork for insurers currently required to put policy loans on deposit.

Section 20.

33-2-701(2) - reduces paperwork and under NAIC accreditation standards, annual and quarterly diskette filings are required by 1/1/96.

Section 21.

33-2-705(6) - the interest rate on unpaid taxes mentioned in 31-1-107 suggests that it must be determined by mutual agreement between the Department and the offending insurer. This practice is problematic and the rate should be set at a more sensible rate.

Section 22.

33-2-708(1)(k) - clarifies licensing fees required of motor club representatives, over which the insurance commissioner has licensing authority pursuant to 61-12-302.

33-2-708(1)(n)(iii) - clarifies that forms submitted must relate to the same policy and prevents insurers from submitting forms together which should be considered separately from one another.

Section 23.

33-2-803(1) - operates in tandem with 33-2-820 to permit insurers to invest in non-dividend paying stocks, which would be a prohibited practice without the amendments. The prohibition is not practical.

Section 24.

33-2-806(6) - raises, upon insurer request, the permissible investment in common stock from 10% of insurer assets to 15%. The department has determined this adjustment to be fiscally

sound.

Section 25.

33-2-820 - see Section 23 comments.

Section 26.

33-2-1111(2)(c)(v) - important for NAIC accreditation standards. The deleted phrase in (2)(c)(v) exempts important registration information from filing.

Section 27.

33-2-1201(6) - the exception for sprinklered risks has no merit and should be removed.

Section 28.

33-2-1216(5)(b)(iii) - see Section 11, 33-2-307(1)(b)(ii) comments.

Section 29.

33-2-1217(3)(4) - provides a definition for the term "qualified United States financial institution" as used in the section. The definition also meets NAIC accreditation recommendations.

Section 30.

33-2-1218 - corrects a 1993 bill drafting error which effectively restricted the law to very old or already cancelled reinsurance agreements. The law should apply to agreements in effect now.

Section 31.

33-2-1510(8) & (10) - clarifies required provisions for controlling producer / controlled insurer agreements by including language which was inadvertently omitted last session.

Section 32.

33-2-1605(4) - corrects a typographical error in the 1993 law.

Section 33.

33-3-431 - eliminates the differentiation between stock and mutual insurers, each of whom require as much oversight as the

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other. Also, the amendments clarify the commissioner approval requirement for repayment of either principle or interest on borrowed surplus. Repayment of interest without oversight may jeopardize an insurer's financial condition.

Section 34.

33-4-202 - currently, the approved farm mutual's articles are filed with the Department, the Secretary of State, the insurer and the insurer's local county clerk. Filing with the county clerk is unnecessary.

Section 35.

33-4-203 - eliminates the unnecessary and superfluous review of a farm mutual's articles by the attorney general.

Section 36.

33-5-401(1)(b) - establishes an appropriate distinction between required surplus funds for domestic reciprocals transacting casualty insurance with and without authority for worker's compensation.

Section 37.

33-7-117 - extends application of new sections embodying the Disclosure of Material Transactions Act to Fraternal Benefit Societies.

Section 38.

33-10-201 - under NAIC accreditation standards, the Life and Health Insurance Guaranty Association Act must be modified in this manner by 1/1/96. The modifications clarify the application provisions of the act.

Section 39.

33-10-202(6) - clarifies the definition of "member insurer" and conforms the act to NAIC accreditation standards.

Section 40.

33-11-102(1) - provides a definition for "completed operations liability" as used in Chapter 11, in conformity with NAIC accreditation standards.

Section 41.

33-11-104(13) - provides a penalty for risk retention groups operating in violation of Montana law. The penalty provision is required by NAIC accreditation standards.

Section 42.

33-11-108(1)(g) - biographical information is needed to ensure that the interests of the membership of the purchasing groups not compromised by controlling members with contradictory interests.

Section 43.

33-14-304(2) - eliminates a reference to "brokers" which is a term not recognized in the Montana Insurance Code.

Section 44.

33-15-301 - clarifies the intended effect of standard provisions requirements as including contract language (provisions) and contract obligations (benefits) in all contracts of insurance (policies and certificates).

Section 45.

33-15-303(3) - creates uniform standards for form designating numbers and revision dates. Currently, this provision is found in the disability chapter, but should apply to insurance forms generally.

Section 46.

33-16-202(1) - eliminates rule promulgation mandate in an area where regulation by rule is not essential.

Section 47.

33-16-235(1) - similar to 33-16-202, this deregulatory amendment eliminates rule and reporting mandates where existing regulatory tools are sufficient.

Section 48.

33-17-102(1)(d) - clarifies the definition of "adjuster" to include licensed third party administrators.

33-17-102(9)(a)(ii) - creates uniformity for the "managing

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general agent" definition throughout the insurance code. This definition conflicted with the one found at 33-2-501.

Section 49.

33-17-211(1)(d) & (e) - limits the time period allowed between examination passage and license applications so that applicants may not use stale tests as basis for licensing. The amendment also clarifies that licenses issued based on Montana residency terminate upon relocation to another state.

Section 50.

33-17-405 - clarifies the commissioner's status as agent for the nonresident person for service of process purposes.

Section 51 & 52.

33-17-503 & 33-17-603 - clarifies that consultant and administrator's application fees, respectively, are to be deposited with the general fund. The amendments also eliminate the need to physically prepare a new license each year for each consultant by establishing continuing licenses.

Section 53.

33-17-1001(2) - permits revocation, suspension, refusal or denial of an insurance agency license where a partner or officer, whether or not a licensed producer, is engaged in prohibited conduct which is injurious to the public's interest.

Section 54.

This section was erroneously included in this bill. No substantive change was made.

Section 55.

33-18-301(3) - establishes policyholder protection standards for funeral insurance policy solicitation and sales.

Section 56 & 57.

33-22-131(1) & (4), 33-22-132(1) & (4) - prevents some mandated benefits from appearing in policies in which it does not make sense to include them (i.e., mammography benefits in accident only policies, phenylketonuria benefits in dental policies, etc.).

Section 58.

33-22-201(6) - eliminates erroneous reference to sections of law which do not exist and prevents inadvertent application of sections later enacted in those reserved sections.

33-22-201(7) - section is taken out of disability chapter and is placed more appropriately in contracts chapter of code (see Section 45), providing for uniformity of all insurance forms, not just disability forms.

Section 59.

33-22-202(3) - eliminates erroneous reference to sections of code which do not exist and prevents inadvertent application of sections later enacted in those reserved sections.

Section 60.

33-22-301 - allows insurers to collect a premium for a new insured (i.e., converting coverage to family coverage in the case of a first born child). The amendment also allows an insurer to require notification of a new insured on a policy.

Section 61.

33-22-303(1) - clarifies that the well-child care benefit provision applies to medical expense disability policies and not disability income policies.

Section 62.

33-22-504(1) & (2) - eliminates distinction between individuals with prior family coverage and those without, and permits newborns of both classes to obtain coverage after birth.

33-22-504(4) - prevents inclusion of newborn coverage in policies in which inclusion is erroneous.

33-22-504(5) - clarifies which policies are required to conform to this provision.

33-22-504(6) - allows insurers to collect a premium for a new insured (i.e., converting coverage to family coverage in the case of a first born child). The amendment also allows an insurer to require notification of a new insured on a policy.

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Section 63.

33-22-508(1) - applies the conversion on termination of eligibility to policies and certificates alike.

Section 64.

33-22-1120(1) - similar to Section 63, the amendment applies Montana long term care policy laws to policies or certificates issued to Montana residents.

Section 65.

33-22-1803(16)(a) - clarifies criteria for consideration of a person as a late enrollee.

33-22-1803(8) - clarifies that gender may not be considered as a case characteristic in determination of rates, pursuant to the unisex insurance law.

Section 66.

33-22-1819(13) - clarifies that monies paid to the small employer carrier reinsurance program are not general fund monies, but monies to be used for the program's obligations.

Section 67.

33-30-102(1) - eliminates erroneous reference to portions of the licensing chapter which are not relevant to health service corporations. Also, the amendments apply the Disclosure of Material Transactions Act to health service corporations.

Section 68.

33-30-107 - reduces paperwork and under NAIC accreditation standards, annual and quarterly diskette filing pursuant to these standards is required by 1/1/96.

Section 69.

33-30-108(3) - clarifies when health service corporation license fees are due.

Section 70.

33-30-202 - eliminates the unnecessary requirement of a health service corporation's annual report. Given the required annual

and quarterly statements, the requirement is redundant.

Section 71.

33-30-204(1)(a) - eliminates unnecessary provisions in light of the amendment to 33-30-311.

Section 72.

33-30-311 - subjects insurance producers for health service corporation to the part of the code regulating insurance producers.

Section 73.

allows insurers to collect a premium for a new insured (i.e., converting coverage to family coverage in the case of a first born child). The amendment also allows an insurer to require notification of a new insured on a policy.

Section 74.

33-31-311(1)(a) - eliminates reference to sections repealed in this bill.

33-31-311(5) - subjects health maintenance organizations to the Material Transactions Disclosure Act (Sections 78 - 81).

Section 75.

Right to return policy - removes section from the disability insurance portion of the bill, includes life insurance free look period, and places section in chapter covering insurance contracts in the insurance code.

Section 76.

See Section 13 comments.

Section 77.

Dating insurance applications - prevents fraudulent collection of insurance benefits for period where insured was not actually covered. Acknowledgement of the purpose of the section prevents application to life insurance contracts where backdating is an acceptable, common industry practice.

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Sections 78 - 81.

Disclosure of Material Transactions Act - under NAIC accreditation standards, this act must be in place by 1/1/97. Generally speaking, the act requires reporting by insurers of significant transactions and events concerning material acquisitions and dispositions of assets, and non-renewals, cancellations, or revisions of ceded reinsurance agreements. The reporting allows regulators to survey insurers' solvency status and is an important component of financial oversight, as well as policyholder and industry protection.

Sections 82 - 94.

Risk Based Capital for Insurers Act - under NAIC accreditation standards, this act must be in place by 1/1/97. Current regulations require a flat surplus minimum for different classes of insurers. The RBC Act tailors each insurer's required surplus to a more realistic amount according to a formula. The surplus minimum is adjusted for each insurer by application of formula factors relevant to the particular insurer. The Act also provides for administrative hearings for insurers disputing the commissioner's determinations under the Act.

Section 95.

Repeals sections 33-30-312 and 33-30-313, both of which are unnecessary after amendments to 33-30-311.

December 1994

EXHIBIT NO. 2

DATE 3-1-95

BILL NO. HB 556

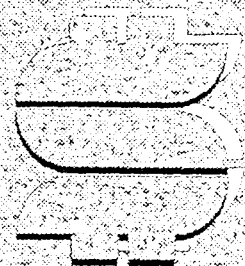
Presented by Frank Cote

NAIC

*National
Association of
Insurance
Commissioners*

The original of this document is stored at the Historical Society at 225 North Roberts Street, Helena, MT 59620-1201. The phone number is 444-2694.

Financial Regulation Standards and Accreditation Program



DATE

March 1, 1995

SENATE COMMITTEE ON

Business and Industry

BILLS BEING HEARD TODAY:

HB 310 Rep. Barnett
HB 336 Rep. Barnett HB 556 Rep. Simon

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PLEASE PRINT

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Check One

Name	Representing	Bill No.	Support	Opp
EARL ROWE	THE BONDSMAN, MISSOULA, MT	HB 336	X	
SCOTT RESTRENT	VALLEY BONDING	HB 336	X	
Dean Crow	Valley Bonds	HB 336	X	
Kelly Ruskick	Big Sky Bail Bonds	HB 336	X	
Marie Andersen	Andersen Bonding	336	X	
Red Jensen	Andersen Bonds	336	X	
Jean Mollin	Arrow Bail Bonds	336	X	
FR. ANK (Cte)	St. Andrew's	556	X	
TOM MATOSICH	MPC	HB 310	X	
ROGER MCGLENN	IIA M	556	X	
GREG JACKSON	WACO/SPIA	556	X	Amend.
Barbara Rant	US WEST	HB 310	X	
Angeline Denmark	Am. Ins. Assoc.	HB 556	X	
R. D. Hahn	State Farm	HB 556	X	

VISITOR REGISTER

PLEASE LEAVE PREPARED STATEMENT WITH COMMITTEE SECRETARY

DATE March 1, 1995

SENATE COMMITTEE ON Business & Industry

BILLS BEING HEARD TODAY: HB 556, HB 310 &
HB 336

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PLEASE PRINT

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Check One

Name	Representing	Bill No.	Support	Oppose
John Alke	MOU	HB 310	☒	☐
TANIA ASK	Blue Cross Blue Shield	HB 556	☒	☐
Denny Moore	ACLI	HB 556	☒	☐

VISITOR REGISTER

PLEASE LEAVE PREPARED STATEMENT WITH COMMITTEE SECRETARY

MINUTES

MONTANA SENATE
54th LEGISLATURE - REGULAR SESSION

COMMITTEE ON BUSINESS & INDUSTRY

Call to Order: By CHAIRMAN JOHN HERTEL, on March 2, 1995, at
8:00 a.m.

ROLL CALL

Members Present:

Sen. John R. Hertel, Chairman (R)
Sen. Steve Benedict, Vice Chairman (R)
Sen. William S. Crismore (R)
Sen. C.A. Casey Emerson (R)
Sen. Ken Miller (R)
Sen. Mike Sprague (R)
Sen. Gary Forrester (D)
Sen. Terry Klampe (D)
Sen. Bill Wilson (D)

Members Excused: N/A

Members Absent: N/A

Staff Present: Bart Campbell, Legislative Council
Lynette Lavin, Committee Secretary

Please Note: These are summary minutes. Testimony and
discussion are paraphrased and condensed.

Committee Business Summary:

Hearing: HB 360, HB 326, HB 502
Executive Action: SB 313 DO PASS
HB 147 BE CONCURRED IN
HB 336 BE CONCURRED IN
HB 556 BE CONCURRED IN AS AMENDED
HB 360 BE CONCURRED IN AS AMENDED
HB 326 BE CONCURRED IN AS AMENDED
HB 502 BE CONCURRED IN

HEARING ON HOUSE BILL 360

Opening Statement by Sponsor:

REP. JOE QUILICI, HD 36, Butte, distributed copies of amendments
as per EXHIBIT #1 and said HB 360 provided for an exception to
the original cost rule when a public purchase was in the best
interest of the public. He referred to Line 17, saying public

SEN. EMERSON remarked if all retail pharmacies qualified for the discount, manufacturers would raise their prices slightly.

Vote: The motion SB 313 DO PASS CARRIED 6-2 by roll call vote #1.

EXECUTIVE ACTION ON HOUSE BILL 147

Motion/Vote: SEN. GARY FORRESTER MOVED HB 147 BE CONCURRED IN. The motion CARRIED UNANIMOUSLY by voice vote.

EXECUTIVE ACTION ON HOUSE BILL 336

Motion/Vote: SEN. TERRY KLAMPE MOVED HB 336 BE CONCURRED IN. The motion CARRIED UNANIMOUSLY by voice vote.

EXECUTIVE ACTION ON HOUSE BILL 556

Bart Campbell presented amendments HB055601.ABC, EXHIBIT #5 and the proposed amendments by the American Council of Life Insurance, EXHIBIT #6, were distributed.

Motion/Vote: SEN. BENEDICT MOVED TO ADOPT AMENDMENTS AS PER EXHIBITS #5 & #6. The motion PASSED UNANIMOUSLY by voice vote.

Discussion: SEN. EMERSON asked if the amendments pertained only to the bill. Mr. Campbell said they deleted one section which had been amended in the original bill, and included two other sections which needed cleanup language.

Motion/Vote: SEN. BENEDICT MOVED HB 556 AS AMENDED BE CONCURRED IN. The motion CARRIED 7-1 on voice vote, with SEN. FORRESTER voting "NO".

EXECUTIVE ACTION ON HOUSE BILL 360

Motion: SEN. CASEY EMERSON MOVED TO ADOPT AMENDMENTS, EXHIBIT #7, hb360amd.

Discussion: Bart Campbell explained EXHIBIT #7 (amendments).

Vote: The motion TO ADOPT AMENDMENTS CARRIED UNANIMOUSLY by voice vote.

Motion/Vote: SEN. GARY FORRESTER MOVED HB 360 AS AMENDED BE CONCURRED IN. The motion CARRIED UNANIMOUSLY by voice vote.

MONTANA SENATE
1995 LEGISLATURE
BUSINESS AND INDUSTRY COMMITTEE

ROLL CALL

DATE _____

3-2-95

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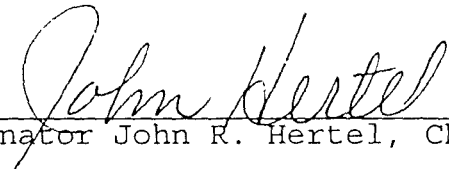
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SENATE STANDING COMMITTEE REPORT

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March 2, 1995

MR. PRESIDENT:

We, your committee on Business and Industry having had under consideration HB 556 (third reading copy -- blue), respectfully report that HB 556 be amended as follows and as so amended be concurred in.

Signed: 

Senator John R. Hertel, Chair

That such amendments read:

1. Title, line 10.

Following: "33-2-1218,"

Insert: "33-2-1394,"

2. Title, line 13.

Strike: "33-17-1001,"

3. Title, line 14.

Following: "33-22-1803,"

Insert: "33-22-1811,"

4. Title, line 15.

Strike: "33-31-311"

Insert: "33-31-111"

5. Title, line 15.

Following: "MCA;"

Strike: "AND"

6. Title, line 16.

Following: "MCA"

Insert: "; AND PROVIDING EFFECTIVE DATES"

7. Page 6, line 20.

Following: "payment"

Insert: "on or"

8. Page 8, line 13.

Following: "insurers"

Insert: "or, in the case of a renewal, the line of insurance has not become available from an authorized insurer"

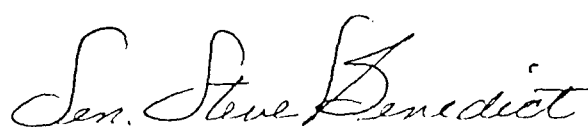
9. Page 8, line 20.

Following: "and"

Insert: "and"

 Amd. Coord.

 Sec. of Senate


Senator Carrying Bill

491137SC.SRF

10. Page 8, line 21.
Strike: subsection (5) in its entirety
Renumber: subsequent subsection

11. Page 15, line 17.
Strike: "1995"
Insert: "1996"

12. Page 17, line 1.
Following: "~~sueh~~"
Insert: "all other"

13. Page 42, line 4.
Insert: "Section 31. Section 33-2-1394, MCA, is amended to read:

"33-2-1394. Settlement of actions against rehabilitator, liquidator, and employees -- court approval -- applicability. (1) If any legal action against an employee for which indemnity may be available under this section is settled prior to final adjudication on the merits, the insurer shall pay the settlement amount on behalf of the employee or indemnify the employee for the settlement amount unless the commissioner determines:

(a) that the claim did not arise out of or by reason of the employee's duties or employment; or

(b) that the claim was caused by the intentional or willful and wanton misconduct of the employee.

(2) In a legal action in which the rehabilitator or liquidator is a defendant, that portion of any settlement relating to the alleged act, error, or omission of the rehabilitator or liquidator is subject to the approval of the court before which the delinquency proceeding is pending. The court may not approve that portion of the settlement if it determines:

(a) that the claim did not arise out of or by reason of the rehabilitator's or liquidator's duties or employment; or

(b) that the claim was caused by the intentional or willful and wanton misconduct of the rehabilitator or liquidator.

(3) This section may not be construed to deprive the rehabilitator, liquidator, or employee of immunity, indemnity, benefit of law, right, or defense available under any provision of law, including, without limitation, the provisions of Title 2, chapter 9.

(4) (a) A Except as otherwise provided, a legal action by a third party does not lie against the rehabilitator, liquidator, or employee based in whole or in part on any alleged act, error, or omission that took place prior to October 1, 1993, unless suit is filed and valid service of process is obtained by October 1, 1994. A legal action that is pending on or filed after September 30, 1993, by a liquidator or a liquidation estate will lie

against a former special deputy liquidator or any employee, agent, or independent contractor retained by a special deputy liquidator without regard to when the alleged act, error, or omission occurred.

(b) Subsections (1) through (3) apply to any suit that is pending on or filed after October 1, 1993, without regard to when the alleged act, error, or omission took place.""

Renumber: subsequent sections

14. Page 43, lines 18 and 19.

Strike: "The" on line 18 through "fees" on line 19

Insert: "A limit on the controlling producer's writings in relation to the controlled insurer's surplus and total writings"

15. Page 68, line 18 through page 69, line 18.

Strike: section 53 in its entirety

Renumber: subsequent sections

16. Page 71, line 14.

Strike: "hospital indemnity,"

17. Page 88, line 27.

Strike: "report" through "license"

Insert: "statement"

18. Page 90, lines 1 through 22.

Strike: section 74 in its entirety

Insert: "**Section 74.** Section 33-31-111, MCA, is amended to read:

"33-31-111. Statutory construction and relationship to other laws. (1) Except as otherwise provided in this chapter, the insurance or health service corporation laws do not apply to any health maintenance organization authorized to transact business under this chapter. This provision does not apply to an insurer or health service corporation licensed and regulated pursuant to the insurance or health service corporation laws of this state except with respect to its health maintenance organization activities authorized and regulated pursuant to this chapter.

(2) Solicitation of enrollees by a health maintenance organization granted a certificate of authority or its representatives may not be construed as a violation of any law relating to solicitation or advertising by health professionals.

(3) A health maintenance organization authorized under this chapter may not be considered to be practicing medicine and is exempt from Title 37, chapter 3, relating to the practice of medicine.

(4) The provisions of this chapter do not exempt a health maintenance organization from the applicable certificate of need

requirements under Title 50, chapter 5, parts 1 and 3.

(5) The provisions of this section do not exempt a health maintenance organization from material transaction disclosure requirements under [sections 78 through 81]. A health maintenance organization must be considered an insurer for the purposes of [sections 78 through 81]."

19. Page 90, line 24.

Following: "Each"

Insert: "individual"

20. Page 106, line 17.

Insert: "Section 95. Section 33-22-1811, MCA, is amended to read:

"33-22-1811. Availability of coverage -- required plans.

(1) (a) As a condition of transacting business in this state with small employers, each small employer carrier shall offer to small employers at least two health benefit plans. One plan must be a basic health benefit plan, and one plan must be a standard health benefit plan.

(b) (i) A small employer carrier shall issue a basic health benefit plan or a standard health benefit plan to any eligible small employer that applies for either plan and agrees to make the required premium payments and to satisfy the other reasonable provisions of the health benefit plan not inconsistent with this part.

(ii) In the case of a small employer carrier that establishes more than one class of business pursuant to 33-22-1808, the small employer carrier shall maintain and offer to eligible small employers at least one basic health benefit plan and at least one standard health benefit plan in each established class of business. A small employer carrier may apply reasonable criteria in determining whether to accept a small employer into a class of business, provided that:

(A) the criteria are not intended to discourage or prevent acceptance of small employers applying for a basic or standard health benefit plan;

(B) the criteria are not related to the health status or claims experience of the small employers' employees;

(C) the criteria are applied consistently to all small employers that apply for coverage in that class of business; and

(D) the small employer carrier provides for the acceptance of all eligible small employers into one or more classes of business.

(iii) The provisions of subsection (1)(b)(ii) may not be applied to a class of business into which the small employer carrier is no longer enrolling new small businesses.

(c) The provisions of this section are effective 180 days

after the commissioner's approval of the basic health benefit plan and the standard health benefit plan developed pursuant to 33-22-1812, provided that if the program created pursuant to 33-22-1818 is not yet operative on that date, the provisions of this section are effective on the date that the program begins operation.

(2) (a) A small employer carrier shall, pursuant to 33-1-501, file the basic health benefit plans and the standard health benefit plans to be used by the small employer carrier.

(b) The commissioner may at any time, after providing notice and an opportunity for a hearing to the small employer carrier, disapprove the continued use by a small employer carrier of a basic or standard health benefit plan on the grounds that the plan does not meet the requirements of this part.

(3) Health benefit plans covering small employers must comply with the following provisions:

(a) A health benefit plan may not, because of a preexisting condition, deny, exclude, or limit benefits for a covered individual for losses incurred more than 12 months following the effective date of the individual's coverage. A health benefit plan may not define a preexisting condition more restrictively than 33-22-110, except that the condition may be excluded for a maximum of 12 months.

(b) A health benefit plan must waive any time period applicable to a preexisting condition exclusion or limitation period with respect to particular services for the period of time an individual was previously covered by qualifying previous coverage that provided benefits with respect to those services if the qualifying previous coverage was continuous to a date not less more than 30 days prior to the submission of an application for new coverage. This subsection (3)(b) does not preclude application of any waiting period applicable to all new enrollees under the health benefit plan.

(c) A health benefit plan may exclude coverage for late enrollees for 18 months or for an 18-month preexisting condition exclusion, provided that if both a period of exclusion from coverage and a preexisting condition exclusion are applicable to a late enrollee, the combined period may not exceed 18 months from the date the individual enrolls for coverage under the health benefit plan.

(d) (i) Requirements used by a small employer carrier in determining whether to provide coverage to a small employer, including requirements for minimum participation of eligible employees and minimum employer contributions, must be applied uniformly among all small employers that have the same number of eligible employees and that apply for coverage or receive coverage from the small employer carrier.

(ii) A small employer carrier may vary the application of

minimum participation requirements and minimum employer contribution requirements only by the size of the small employer group.

(e) (i) If a small employer carrier offers coverage to a small employer, the small employer carrier shall offer coverage to all of the eligible employees of a small employer and their dependents. A small employer carrier may not offer coverage only to certain individuals in a small employer group or only to part of the group, except in the case of late enrollees as provided in subsection (3)(c).

(ii) A small employer carrier may not modify a basic or standard health benefit plan with respect to a small employer or any eligible employee or dependent, through riders, endorsements, or otherwise, to restrict or exclude coverage for certain diseases or medical conditions otherwise covered by the health benefit plan.

(4) (a) A small employer carrier may not be required to offer coverage or accept applications pursuant to subsection (1) in the case of the following:

(i) to a small employer when the small employer is not physically located in the carrier's established geographic service area;

(ii) to an employee when the employee does not work or reside within the carrier's established geographic service area; or

(iii) within an area where the small employer carrier reasonably anticipates and demonstrates to the satisfaction of the commissioner that it will not have the capacity within its established geographic service area to deliver service adequately to the members of a group because of its obligations to existing group policyholders and enrollees.

(b) A small employer carrier may not be required to provide coverage to small employers pursuant to subsection (1) for any period of time for which the commissioner determines that requiring the acceptance of small employers in accordance with the provisions of subsection (1) would place the small employer carrier in a financially impaired condition."

Renumber: subsequent sections

21. Page 107, line 7.

Insert: "NEW SECTION. Section 99. Effective dates. (1)

[Section 31 and this section] are effective on passage and approval.

(2) [Sections 1 through 30 and 32 through 98] are effective October 1, 1995."

-END-

HOUSE BILL NO. 556

INTRODUCED BY SIMON, BENEDICT

BY REQUEST OF THE STATE AUDITOR

A BILL FOR AN ACT ENTITLED: "AN ACT GENERALLY REVISING STATE INSURANCE LAWS; PROVIDING FOR THE DISCLOSURE OF MATERIAL TRANSACTIONS; CREATING A RISK-BASED CAPITAL FOR INSURERS ACT; AMENDING SECTIONS 2-6-109, 33-1-207, 33-1-208, 33-1-209, 33-1-311, 33-1-413, 33-1-501, 33-2-117, 33-2-301, 33-2-302, 33-2-305, 33-2-307, 33-2-501, 33-2-521, 33-2-523, 33-2-525, 33-2-526, 33-2-528, 33-2-529, 33-2-531, 33-2-701, 33-2-705, 33-2-708, 33-2-803, 33-2-806, 33-2-820, 33-2-1111, 33-2-1201, 33-2-1216, 33-2-1217, 33-2-1218, 33-2-1394, 33-2-1510, 33-2-1605, 33-3-431, 33-4-202, 33-4-203, 33-5-401, 33-7-117, 33-10-201, 33-10-202, 33-11-102, 33-11-104, 33-11-108, 33-14-304, 33-15-301, 33-15-303, 33-16-202, 33-16-235, 33-17-102, 33-17-211, 33-17-405, 33-17-503, 33-17-603, ~~33-17-1001~~, 33-18-212, 33-18-301, 33-22-131, 33-22-132, 33-22-201, 33-22-202, 33-22-301, 33-22-303, 33-22-504, 33-22-508, 33-22-1120, 33-22-1803, 33-22-1811, 33-22-1819, 33-30-102, 33-30-107, 33-30-108, 33-30-202, 33-30-204, 33-30-311, 33-30-1001, AND ~~33-31-311~~ 33-31-111, MCA; AND REPEALING SECTIONS 33-30-312 AND 33-30-313, MCA; AND PROVIDING EFFECTIVE DATES."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:

Section 1. Section 2-6-109, MCA, is amended to read:

"2-6-109. Prohibition on distribution or sale of mailing lists -- exceptions -- penalty. (1) Except as provided in subsections (3) through (7), in order to protect the privacy of those who deal with state and local government:

(a) ~~an~~ an agency may not distribute or sell for use as a mailing list any list of persons without first securing the permission of those on the list; and

(b) ~~a~~ a list of persons prepared by the agency may not be used as a mailing list except by the agency or another agency without first securing the permission of those on the list.

(2) As used in this section, "agency" means any board, bureau, commission, department, division, authority, or officer of the state or a local government.

1 (3) Except as provided in 30-9-403, this section does not prevent an individual from compiling a
2 mailing list by examination of original documents or applications which are otherwise open to public
3 inspection.

4 (4) This section does not apply to the lists of registered electors and the new voter lists provided
5 for in 13-2-115 and 13-38-103, to lists of the names of employees governed by Title 39, chapter 31, or
6 to lists of persons holding driver's licenses provided for under 61-5-126.

7 (5) This section ~~shall~~ does not prevent an agency from providing a list to persons providing
8 preclicensing or continuing educational courses subject to Title 20, chapter 30, or specifically exempted
9 ~~therefrom~~ as provided in 20-30-102, or subject to Title 33, chapter 17.

10 (6) This section does not apply to the right of access either by Montana law enforcement agencies
11 or, by purchase or otherwise, of public records dealing with motor vehicle registration.

12 (7) This section does not apply to a corporate information list developed by the secretary of state
13 containing the name, address, registered agent, officers, and directors of business, nonprofit, religious,
14 professional, and close corporations authorized to do business in this state.

15 (8) A person violating the provisions of subsection (1)(b) is guilty of a misdemeanor."
16

17 **Section 2.** Section 33-1-207, MCA, is amended to read:

18 **"33-1-207. Disability insurance.** (1) Disability insurance, including credit disability insurance, is
19 insurance of human beings: (a) against bodily injury, disablement, or death by accident or accidental means
20 or the medical expense thereof or indemnity involved; or

21 (b) against disablement or medical expense or indemnity resulting from sickness and every
22 insurance appertaining thereto.

23 (2) Transaction of disability insurance does not include workers' compensation insurance."
24

25 **Section 3.** Section 33-1-208, MCA, is amended to read:

26 **"33-1-208. Life insurance.** Life insurance, including credit life insurance, is insurance on human
27 lives. The transaction of life insurance includes ~~also~~ the granting of endowment benefits, additional benefits
28 in event of death or dismemberment by accident or accidental means, additional benefits in event of the
29 insured's disability, benefits that provide reimbursement or payment for long-term home health care or
30 long-term care in a nursing home or other related institution, and optional modes of settlement of proceeds

of life insurance. Transaction of life insurance does not include workers' compensation insurance."

Section 4. Section 33-1-209, MCA, is amended to read:

"33-1-209. Marine protection and indemnity and wet marine insurance. (1) ~~Marine insurance includes marine protection and indemnity insurance, meaning insurance against, or against legal liability of the insured for, loss, damage, or expense arising out of or incident to the ownership, operation, chartering, maintenance, use, repair, or construction of any vessel, craft, or instrumentality in use in ocean or inland waterways, including liability of the insured for personal injury, illness, or death or for loss of or damage to the property of another person.~~ Marine and transportation insurance means insurance against loss of or damage to:

(a) vessels, craft, aircraft, vehicles, goods, freights, cargoes, merchandise, effects, disbursements, profits, money, securities, choses in action, evidences of debt, valuable papers, bottomry, respondentia, and any interest therein, with respect to risks and perils, including war risks, marine builder's risks, and personal property floater risks, of navigation and transportation or while being assembled, packed, crated, baled, compressed, or similarly prepared for shipment, while awaiting shipment, or during any delays, storage, transshipment, or reshipment;

(b) person or property in connection with marine, transit, or transportation insurance, including liability for loss or damage to either person or property incident to the construction, repair, operation, maintenance, or use of the subject matter of the insurance, but not including life insurance, surety bonds, or insurance against bodily injury arising out of the ownership, maintenance, or use of an automobile;

(c) jewels, jewelry, or precious metals, whether in the course of transportation or otherwise; and

(d) bridges; tunnels; and other instrumentalities of transportation and communication, excluding buildings and their furnishings, fixed contents, and supplies held in storage (unless fire, tornado, sprinkler leakage, hail, explosion, earthquake, riot, or civil commotion are the only hazards to be covered); piers; wharves; docks; slips; and other aids to navigation and transportation, including drydocks, marina railways, and dams and appurtenant facilities for the control of waterways.

(2) Marine protection and indemnity insurance means insurance against liability of the insured for loss, damage, or expense incident to ownership, operation, charter, maintenance, use, repair, or construction of any vessel, craft, or instrumentality for use in ocean or inland waterways. The term includes insurance against the liability of the insured for personal injury, illness, death, or loss or damage

1 of the property of another person.

2 ~~(2)(3)~~ For the purposes of this code, wet marine and transportation insurance is that part of marine
3 insurance ~~which~~ that includes only:

4 (a) insurance upon vessels, crafts, and hulls and of interests ~~therein or with relation thereto~~ in or
5 relating to the vessels, crafts, and hulls;

6 (b) insurance of marine builders' risks, marine war risks, and contracts of marine protection and
7 indemnity insurance;

8 (c) insurance of freights and disbursements pertaining to a subject of insurance ~~coming within~~
9 subject to this subsection; and

10 (d) insurance of personal property and interests ~~therein~~ in the personal property, in the course of
11 exportation from or importation into any country and in the course of transportation coastwise or on inland
12 waters, including transportation by land, water, or air from point of origin to final destination, ~~in~~ with
13 respect to, ~~appertaining to, or in connection with any and all~~ risks or perils of navigation, transit, or
14 transportation or while being prepared for ~~and or~~ while awaiting shipment ~~and or~~ during any delays, storage,
15 transshipment, or reshipment incident ~~thereto~~ to preparation or shipment."

16
17 **Section 5.** Section 33-1-311, MCA, is amended to read:

18 **"33-1-311. General powers and duties.** (1) The commissioner shall enforce the applicable
19 provisions of ~~this code~~ the laws of this state and shall execute the duties imposed on the commissioner by
20 ~~this code~~ the laws of this state.

21 (2) The commissioner ~~shall have~~ has the powers and authority expressly conferred upon the
22 commissioner by or reasonably implied from the provisions of ~~this code~~ the laws of this state.

23 (3) The commissioner shall administer the department to ensure that the interests of insurance
24 consumers are protected.

25 (4) The commissioner may conduct examinations and investigations of insurance matters, in
26 addition to examinations and investigations expressly authorized, as the commissioner considers proper,
27 to determine whether any person has violated any provision of ~~this code~~ the laws of this state or to secure
28 information useful in the lawful administration of any provision. The cost of additional examinations and
29 investigations must be borne by the state.

30 ~~(5) The commissioner has additional powers and duties as provided by other laws of this state.~~

1 ~~(6)~~(5) The department is a criminal justice agency as defined in 44-5-103."

2
3 **Section 6.** Section 33-1-501, MCA, is amended to read:

4 **"33-1-501. Filing and approval of forms.** (1) (a) An insurance policy or annuity contract form,
5 certificate, enrollment form, application form, printed rider or endorsement form, or form of renewal
6 certificate may not be delivered or issued for delivery in Montana unless the form has been filed with and
7 approved by the commissioner and, if required, the regulatory official of the state of domicile of the insurer,
8 ~~if required~~. This provision does not apply to surety bonds or policies, riders, endorsements, or forms of
9 unique character designed for and used with relation to insurance upon a particular subject or that relate
10 to the manner of distribution of benefits or to the reservation of rights and benefits under life or disability
11 insurance policies and are used at the request of the individual policyholder, contract holder, or certificate
12 holder. Forms for use in property, marine, ~~other than ocean marine and foreign trade coverages~~, casualty,
13 and surety insurance coverages may be filed by a rating organization on behalf of its members and
14 subscribers or by a member or subscriber on its own behalf.

15 (b) The approval of an insurance policy or annuity contract form, certificate, enrollment form,
16 application form, or other related insurance form by the state of domicile may be waived by the
17 commissioner if the commissioner considers the requirements of subsection (1)(a) unnecessary for the
18 protection of Montana insurance consumers. If the requirement is waived, an insurer shall notify the
19 commissioner in writing within 10 days of disapproval, denial, or withdrawal of approval of a form by the
20 state of domicile.

21 (2) The filing must be made not less than 60 days in advance of delivery. Approval of a form by
22 the commissioner constitutes a waiver of any unexpired portion of the waiting period. The commissioner
23 may extend by not more than an additional 60 days the period within which the commissioner may approve
24 or disapprove a form by giving notice of the extension before expiration of the initial 60-day period. The
25 commissioner may at any time, after notice and for cause shown, withdraw any approval.

26 (3) ~~An order of~~ Notice by the commissioner disapproving a form or withdrawing a previous approval
27 must state the grounds for disapproval or withdrawal in sufficient detail to inform the insurer.

28 (4) The commissioner may exempt from the requirements of this section, for so long as the
29 commissioner considers proper, an insurance document, form, or type of document or form ~~specified~~ to
30 which, in the commissioner's opinion, this section may not practicably be applied or the filing and approval

1 of which are, ~~in the commissioner's opinion,~~ not desirable or necessary for the protection of the public.

2 (5) This section applies to a form used by a domestic insurer for delivery in a jurisdiction outside
3 Montana if the insurance supervisory official of the jurisdiction informs the commissioner that the form is
4 not subject to approval or disapproval by the official and upon the commissioner's order requiring the form
5 to be submitted to the commissioner for the purpose. The same standards apply to these forms as apply
6 to forms for domestic use.

7 (6) This section and 33-1-502 do not apply to:

8 (a) reinsurance;

9 (b) policies or contracts not issued for delivery in Montana or delivered in Montana, except as
10 provided in subsection (5);

11 (c) ocean marine and foreign trade insurances.

12 (7) Except as provided in chapter 21, group certificates that are delivered or issued for delivery in
13 Montana for group insurance policies effectuated and delivered outside Montana but covering persons
14 resident in Montana must be filed with the commissioner upon request. The certificates must meet the
15 minimum provisions mandated by Montana if Montana law prevails over conflicting provisions of other state
16 law."

17
18 **Section 7.** Section 33-2-117, MCA, is amended to read:

19 **"33-2-117. Continuance, expiration, reinstatement, and amendment of certificate of authority. (1)**

20 Certificates of authority issued or renewed under this code ~~shall~~ must continue in force as long as the
21 insurer is entitled thereto under this code and until suspended or revoked or otherwise terminated; ~~subject,~~
22 ~~however,~~ A certificate is subject to continuance of the certificate by the insurer each year by payment ON
23 OR prior to May 15 March 1 of the continuation fee provided in 33-2-708.

24 (2) If not ~~so~~ continued by the insurer, ~~its the~~ certificate of authority ~~shall expire~~ expires at midnight
25 on May 31 ~~next~~ following ~~such~~ failure of the insurer ~~so~~ to continue it in force. The commissioner shall
26 promptly notify the insurer of ~~the occurrence of any such failure resulting in impending~~ its failure to pay
27 the continuation fee that can result in the expiration of its certificate of authority.

28 (3) The commissioner may, ~~in his discretion,~~ reinstate a certificate of authority ~~which that~~ the
29 insurer has inadvertently permitted to expire, after the insurer ~~has fully cured all its~~ cures any failures ~~which~~
30 ~~resulted~~ resulting in ~~such~~ expiration and upon payment ~~by the insurer~~ of the fee for reinstatement in

1 addition to the current continuation fee, as provided in 33-2-708. Otherwise, the insurer ~~shall~~ may be
2 granted another certificate of authority only after filing an application ~~therefor~~ and meeting all other
3 requirements ~~as~~ for an original certificate of authority in this state.

4 (4) The commissioner may amend a certificate of authority at any time to accord with changes in
5 the insurer's charter of insuring powers."

6
7 **Section 8.** Section 33-2-301, MCA, is amended to read:

8 **"33-2-301. Short title -- purpose -- definitions.** (1) This part constitutes and may be referred to as
9 "The Surplus Lines Insurance Law".

10 (2) This part must be applied to:

11 (a) protect persons seeking insurance in this state;

12 (b) permit surplus lines insurance to be placed with reputable and financially sound unauthorized
13 insurers and to be exported from this state pursuant to this part;

14 (c) establish a system of regulation that will permit orderly access to surplus lines insurance in this
15 state and encourage authorized insurers to provide new and innovative types of insurance to consumers
16 in this state; and

17 (d) protect revenues of this state.

18 (3) As used in this part, the following definitions apply:

19 (a) "Authorized insurer" means an insurer authorized pursuant to 33-2-101 to transact insurance
20 in this state.

21 (b) "Eligible surplus lines insurer" means an unauthorized insurer with which a surplus lines
22 insurance producer may place surplus lines insurance under 33-2-307.

23 (c) "Export" means to place surplus lines insurance with an unauthorized insurer.

24 ~~(d) "Kind of insurance" means one of the types of insurance required to be reported in the annual~~
25 ~~statement filed with the commissioner by an authorized insurer.~~

26 ~~(e)~~ (d) "Producing insurance producer" means the individual insurance producer dealing directly with
27 the person seeking insurance.

28 ~~(f)~~ (e) "Surplus lines insurance" means any insurance ~~for~~ risks resident, located, or to be performed
29 in this state ~~permitted to be placed through a surplus lines insurance producer with an unauthorized insurer~~
30 eligible to accept the insurance. The term does not include the kinds of insurance exempted under

1 33-2-317.

2 ~~(g)(f)~~ "Surplus lines insurance producer" means an individual, partnership, or corporation licensed
3 under 33-2-305 to place surplus lines insurance ~~on risks resident, located, or to be performed in this state~~
4 with unauthorized insurers eligible to accept ~~such~~ the insurance.

5 ~~(h)(g)~~ "Unauthorized insurer" means an insurer not authorized pursuant to 33-2-101 to transact
6 insurance in this state. The term includes insurance exchanges authorized under the laws of other states."
7

8 **Section 9.** Section 33-2-302, MCA, is amended to read:

9 **"33-2-302. Conditions precedent to sale of surplus lines insurance.** ~~Insurance may be procured~~
10 ~~through a licensed surplus lines insurance producer from~~ A producing insurance producer may request a
11 surplus lines insurance producer to place or a surplus lines insurance producer may place a contract of
12 insurance with an unauthorized insurer if:

13 (1) the insurer is an eligible surplus lines insurer;

14 (2) the line of insurance or the full amount of the line of insurance cannot be obtained from
15 authorized insurers OR, IN THE CASE OF A RENEWAL, THE LINE OF INSURANCE HAS NOT BECOME
16 AVAILABLE FROM AN AUTHORIZED INSURER;

17 (3) the producing insurance producer makes a diligent effort to place the business with a minimum
18 of three insurers authorized and actually transacting that line of business in this state. If fewer than three
19 insurers are authorized and actually transacting the line of business in this state, diligent effort must be met
20 by searching this lesser market.

21 (4) the insurance is not procured for the purpose of securing:

22 (a) a lower premium rate than would be accepted by an authorized insurer; or

23 (b) an advantage in terms of the insurance contract; ~~and~~ AND

24 ~~(5) in case of renewal, the line has not become available from an authorized insurer; and~~

25 ~~(5)(6)(5)~~ all other requirements of this part are met."
26

27 **Section 10.** Section 33-2-305, MCA, is amended to read:

28 **"33-2-305. Licensing of surplus lines insurance producer -- fee and bond.** (1) A person may not
29 ~~procure~~ place a contract of surplus lines insurance with an unauthorized insurer unless the person is
30 licensed as a property and casualty insurance producer and possesses a current surplus lines insurance

1 license issued by the commissioner.

2 (2) The commissioner shall issue a surplus lines insurance license to any qualified holder of a
3 current property and casualty insurance producer license only if the insurance producer has:

4 (a) remitted to the commissioner the annual fee prescribed by 33-2-708;

5 (b) submitted to the commissioner a completed license application on a form supplied by the
6 commissioner;

7 (c) been licensed as a property and casualty insurance producer continuously for 5 years or more;
8 and

9 (d) filed with the commissioner and, for as long as the license remains in effect, kept in force a
10 bond in favor of the state of Montana in the amount of \$10,000, with authorized corporate sureties
11 approved by the commissioner. The bond must be conditioned that the insurance producer will conduct
12 business under the license in accordance with the provisions of The Surplus Lines Insurance Law and that
13 the insurance producer will promptly remit the taxes provided in 33-2-311. The bond may not be terminated
14 unless the surety gives the surplus lines insurance producer, the producing insurance producer, and the
15 commissioner at least 30 days' prior written notice of termination.

16 (3) The license expires on April 1 after its date of issue. A surplus lines insurance producer shall
17 renew the license on or before March 1 of each year upon payment of the annual renewal fee prescribed
18 in 33-2-708. A surplus lines insurance producer who fails to apply for a renewal of the license on or before
19 March 1 shall pay a fine of \$100 before the commissioner renews the license.

20 (4) A corporation is eligible to be licensed as a surplus lines insurance producer if:

21 (a) the corporate license lists the individuals within the corporation who have satisfied the
22 requirements of this part to become surplus lines insurance producers; and

23 (b) only those individuals listed on the corporate license transact surplus lines insurance.

24 (5) This section may not be construed to require agents, producers, or brokers acting as
25 intermediaries between a surplus lines insurance producer and an unauthorized insurer under this part to
26 hold a valid Montana surplus lines insurance producer's license."

27
28 **Section 11.** Section 33-2-307, MCA, is amended to read:

29 **"33-2-307. Requirements for eligible surplus lines insurers.** (1) A surplus lines insurance producer
30 may not place insurance with an unauthorized insurer unless, at the time of placement, the unauthorized

1 insurer:

2 (a) has established satisfactory evidence of good reputation and financial integrity; and

3 (b) is qualified under one of the following subsections:

4 (i) the insurer maintains capital and surplus or its equivalent under the laws of its state of domicile,
5 which equals the greater of:

6 (A) the minimum capital and surplus requirements of 33-2-109 and 33-2-110; or

7 (B) ~~\$3~~ \$7 million. An insurer possessing less than ~~\$4~~ \$6 million capital and surplus may satisfy the
8 requirements of this subsection upon an affirmative finding of acceptability by the commissioner. The
9 commissioner's finding must be based upon such factors as quality of management, capital, and surplus
10 of a parent company; company underwriting profit and investment income trends; and company record and
11 reputation within the industry. The commissioner may not make an affirmative finding of acceptability
12 when the surplus lines insurer's capital and surplus is less than ~~\$3~~ \$6 million.

13 (ii) in the case of Lloyd's or another similar ~~unincorporated~~ group of including incorporated and
14 unincorporated alien ~~individual~~ insurers, the insurer maintains a trust fund of not less than \$50 million as
15 security to the full amount of capital and surplus for all policyholders and creditors in the United States of
16 each member of the group. The incorporated members of the group may not engage in any business other
17 than underwriting as a member of the group and must be subject to the same level of solvency regulation
18 and control by the groups of domiciliary regulators as are the unincorporated members. The trust must
19 comply with the terms and conditions established in subsection (1)(b)(iv) for alien insurers.

20 (iii) in the case of an insurance exchange created by the laws of individual states, the insurer
21 maintains capital and surplus, or their substantial equivalent, of not less than \$15 million in the aggregate.
22 For an insurance exchange that maintains funds for the protection of each insurance exchange policyholder,
23 each individual syndicate shall maintain minimum capital and surplus, or their substantial equivalent, of not
24 less than \$1.5 million. If the insurance exchange does not maintain funds for the protection of each
25 insurance exchange policyholder, each individual syndicate shall meet the minimum capital and surplus
26 requirements of subsection (1)(b)(i).

27 (iv) in the case of an alien insurer, the insurer maintains in the United States an irrevocable trust
28 fund in either a national bank or a member of the federal reserve system, in an amount not less than \$1.5
29 million, for the protection of all its policyholders in the United States and the trust fund consists of cash,
30 securities, or letters of credit or of investments of substantially the same character and quality as those

1 which are eligible investments for the capital and statutory reserves of insurers authorized to write like kinds
2 of insurance in this state. The trust fund, which must be included in any calculation of capital and surplus
3 or its equivalent, must have an expiration date that may not at any time be less than 5 years. In addition,
4 the alien insurer must appear on the national association of insurance commissioners' Non-Admitted
5 Insurers Quarterly Listing.

6 (c) has provided the commissioner a copy of its current annual statement, certified by the insurer
7 no more than 6 months after the close of the period reported upon, {or quarterly if considered necessary
8 by the commissioner}, and which is either:

9 (i) filed with and approved by the regulatory authority in the state of domicile of the unauthorized
10 insurer; or

11 (ii) certified by an accounting or auditing firm licensed in the jurisdiction of the insurer's state of
12 domicile.

13 (2) In the case of an insurance exchange, the statement required by subsection (1)(c) may be an
14 aggregate combined statement of all underwriting syndicates operating during the period reported.

15 (3) In addition to meeting the requirements in subsection (1), an insurer is an eligible surplus lines
16 insurer only if it appears on the most recent list of eligible surplus lines insurers published at least
17 semiannually by the commissioner. This subsection does not require the commissioner to place or maintain
18 the name of any unauthorized insurer on the list of eligible surplus lines insurers. An action may not lie
19 against the commissioner or an employee of the commissioner for anything said in issuing the list of eligible
20 surplus lines insurers referred to in this subsection.

21 (4) (a) The commissioner may declare an eligible surplus lines insurer ineligible if at any time the
22 commissioner has reason to believe that it:

- 23 (i) is in unsound financial condition;
24 (ii) is no longer eligible under subsections (1) through (3);
25 (iii) has willfully violated the laws of this state; or
26 (iv) does not make reasonably prompt payment of just losses and claims in this state or elsewhere.

27 (b) The commissioner shall promptly mail notice of all declarations to each surplus lines insurance
28 producer.

29 (5) As used in this section, the following definitions apply:

30 (a) "Capital", as used in the financial requirements of this section, means funds invested in for

1 stocks or other evidences of ownership.

2 (b) "Surplus", as used in the financial requirements of this section, means funds over and above
3 liabilities and capital of the insurer for the protection of policyholders."

4

5 **Section 12.** Section 33-2-501, MCA, is amended to read:

6 **"33-2-501. Assets allowed.** In any determination of the financial condition of an insurer, there
7 must be allowed as assets only assets that are owned by the insurer and that consist of:

8 (1) cash in the possession of the insurer or in transit under its control and including the true
9 balance of any deposit in a solvent bank or trust company;

10 (2) investments, securities, properties, and loans acquired or held in accordance with this code and
11 in connection therewith the following items:

12 (a) interest due or accrued on any bond or evidence of indebtedness which is not in default and
13 which is not valued on a basis including accrued interest;

14 (b) declared and unpaid dividends on stock and shares unless the amount has otherwise been
15 allowed as an asset;

16 (c) interest due or accrued upon a collateral loan in an amount not to exceed 1 year's interest on
17 the loan;

18 (d) interest due or accrued on deposits in solvent banks and trust companies and interest due or
19 accrued on other assets, if the interest is in the judgment of the commissioner a collectible asset;

20 (e) interest due or accrued on a mortgage loan in an amount not exceeding in any event the
21 amount, if any, of the excess of the value of the property less delinquent taxes on the property over the
22 unpaid principal. Interest accrued for a period in excess of 18 months may not be allowed as an asset.

23 (f) rent due or accrued on real property if the rent is not in arrears for more than 3 months and rent
24 more than 3 months in arrears if the payment of the rent is adequately secured by property held in the
25 name of the tenant and conveyed to the insurer as collateral;

26 (g) the unaccrued portion of taxes paid prior to the due date on real property;

27 (3) premium notes, policy loans, and other policy assets and liens on policies and certificates of
28 life insurance and annuity contracts and accrued interest, in an amount not exceeding the legal reserve and
29 other policy liabilities carried on each individual policy;

30 (4) the net amount of uncollected and deferred premiums and annuity considerations in the case

1 of a life insurer;

2 (5) premiums in the course of collection, other than for life insurance, not more than 3 months past
3 due, less commissions payable on the premiums. The limitation in this subsection does not apply to
4 premiums payable directly or indirectly by the United States government or by any of its instrumentalities.

5 (6) installment premiums other than life insurance premiums to the extent of the unearned premium
6 reserve carried on the policy to which premiums apply;

7 (7) notes and like written obligations not past due, taken for premiums other than life insurance
8 premiums, on policies permitted to be issued on that basis, to the extent of the unearned premium reserves
9 carried on the policies;

10 (8) the full amount of reinsurance recoverable by a ceding insurer from a solvent reinsurer and
11 which reinsurance is authorized under chapter 2, part 12;

12 (9) amounts receivable by an assuming insurer representing funds withheld by a solvent ceding
13 insurer under a reinsurance treaty;

14 (10) deposits or equities recoverable from underwriting associations, syndicates, and reinsurance
15 funds or from any suspended banking institution, to the extent considered by the commissioner available
16 for the payment of losses and claims and at values to be determined by the commissioner;

17 (11) electronic data processing equipment if the cost of the equipment is at least \$100,000, which
18 ~~cost must be~~ amortized in full over a period of not to exceed ~~40~~ 8 calendar years. However, with regard
19 ~~to life insurers, the equipment must be allowed as an asset if the cost of the equipment is at least \$25,000,~~
20 ~~which cost must be amortized in full over a period of not to exceed 5 calendar years, and the amount of~~
21 the asset allowed may not exceed 1% of the total of the other allowable assets of the insurer.

22 (12) all assets, whether or not consistent with the provisions of this section, as may be allowed
23 pursuant to the annual statement form approved by the commissioner for the kinds of insurance to be
24 reported upon in the annual statement;

25 (13) other assets, not inconsistent with the provisions of this section, considered by the
26 commissioner to be available for the payment of losses and claims, at values to be determined by the
27 commissioner."

28
29 **Section 13.** Section 33-2-521, MCA, is amended to read:

30 **"33-2-521. Standard valuation of reserve liabilities law -- life insurance.** (1) The commissioner

1 shall annually value or cause to be valued the reserve liabilities (~~hereinafter called~~ reserves) for all
2 outstanding life insurance policies and annuity and pure endowment contracts of every life insurer doing
3 business in this state and may certify the amount of any ~~such~~ reserves, specifying the mortality table or
4 tables, rate or rates of interest, and methods (net level premium method or other) used in the calculation
5 of ~~such~~ reserves. In calculating ~~such~~ the reserves, ~~he~~ the commissioner may use group methods and
6 approximate averages for fractions of a year or otherwise. ~~In the case of an alien insurer, such valuation~~
7 ~~shall be limited to its insurance transactions in the United States.~~

8 (2) ~~For the purpose of making such valuation, the commissioner may employ a competent actuary~~
9 ~~who shall be paid by the insurer for which the service is rendered; but a domestic insurer may make such~~
10 ~~valuation and it may be received by the commissioner upon satisfactory proof of its correctness. In lieu of~~
11 ~~the valuation of the reserves herein required in this section of any foreign or alien insurer, the commissioner~~
12 ~~may accept any valuation made or caused to be made by the insurance supervisory official of any state or~~
13 ~~other jurisdiction when such the valuation complies with the minimum standard herein provided in this~~
14 ~~section and if the official of such the other state or jurisdiction accepts as sufficient and valid for all legal~~
15 ~~purposes the certificate of valuation of the commissioner when such the certificate states the valuation to~~
16 ~~have been made in a specified manner according to which the aggregate reserves would be at least as large~~
17 ~~as if they had been computed in the manner prescribed by the law of that state or jurisdiction.~~

18 (3) Any insurer ~~which at any time shall have~~ that has adopted any standard of valuation producing
19 greater aggregate reserves than those calculated according to the minimum standard ~~herein provided in this~~
20 section may, with the approval of the commissioner, adopt any lower standard of valuation but not lower
21 than the minimum ~~herein provided in this section.~~ For the purposes of this section, the holding of additional
22 reserves previously determined by a qualified actuary to be necessary to render the opinion required in
23 subsection (4) may not be considered to be the adoption of a higher standard of valuation.

24 (4) (a) Each life insurer doing business in this state shall annually submit the opinion of a qualified
25 actuary as to whether the reserves and related actuarial items held in support of the policies and contracts
26 specified by the commissioner by rule are computed appropriately, are based on assumptions that satisfy
27 contractual provisions, are consistent with prior reported amounts, and comply with applicable laws of this
28 state. The commissioner by rule shall define the specifics of this opinion and add any other items
29 considered necessary to its scope.

30 (b) Each life insurer, except as exempted by or pursuant to regulation, shall also annually include

1 in the opinion required by subsection (4)(a) an opinion of the same qualified actuary as to whether the
2 reserves and related actuarial items held in support of the policies and contracts specified by the
3 commissioner by rule, when considered in light of the assets held by the insurer with respect to the
4 reserves and related actuarial items, including but not limited to the investment earnings on the assets and
5 the considerations anticipated to be received and retained under the policies and contracts, make adequate
6 provision for the insurer's obligations under the policies and contracts, including but not limited to the
7 benefits under and expenses associated with the policies and contracts.

8 (c) The commissioner may provide by rule for a transition period for establishing any higher
9 reserves that the qualified actuary may consider necessary in order to render the opinion required by this
10 subsection (4).

11 (d) Each opinion required by this subsection (4) must be governed by the following provisions:

12 (i) A memorandum, in form and substance acceptable to the commissioner as specified by rule,
13 must be prepared to support each actuarial opinion.

14 (ii) If the insurer fails to provide a supporting memorandum at the request of the commissioner
15 within a period specified by rule or if the commissioner determines that the supporting memorandum
16 provided by the insurer fails to meet the standards prescribed by the rules or is otherwise unacceptable to
17 the commissioner, the commissioner may engage a qualified actuary at the expense of the insurer to review
18 the opinion and the basis for the opinion and to prepare any supporting memorandum as is required by the
19 commissioner.

20 (iii) The opinion must be submitted with the annual statement reflecting the valuation of the reserve
21 liabilities for each year ending on or after December 31, ~~1995~~ 1996.

22 (iv) The opinion must apply to all business in force, including individual and group health insurance
23 plans, in form and substance acceptable to the commissioner as specified by rule.

24 (v) The opinion must be based on standards adopted from time to time by the actuarial standards
25 board and on additional standards as the commissioner may prescribe by rule.

26 (vi) In the case of an opinion required to be submitted by a foreign or alien insurer, the
27 commissioner may accept the opinion filed by that insurer with the insurance supervisory official of another
28 state if the commissioner determines that the opinion reasonably meets the requirements applicable to a
29 company domiciled in this state.

30 (vii) Except in cases of fraud or willful misconduct, the qualified actuary is not liable for damages

1 to any person, other than the insurer and the commissioner, for any act, error, omission, decision, or
2 conduct with respect to the actuary's opinion.

3 (viii) Disciplinary action by the commissioner against the insurer or the qualified actuary must be
4 defined in rules by the commissioner.

5 (ix) Any memorandum in support of the opinion and any other material provided by the insurer to
6 the commissioner in connection with those items must be kept confidential by the commissioner, may not
7 be made public, and is subject to subpoena, other than for the purpose of defending an action seeking
8 damages from any person by reason of any action required by this subsection (4) or by rules promulgated
9 under this subsection (4). However, the memorandum or other material may otherwise be released by the
10 commissioner:

11 (A) with the written consent of the insurer; or

12 (B) to the American academy of actuaries upon request stating that the memorandum or other
13 material is required for the purpose of professional disciplinary proceedings and setting forth procedures
14 satisfactory to the commissioner for preserving the confidentiality of the memorandum or other material.
15 Once any portion of the confidential memorandum is cited by the insurer in its marketing, is cited before
16 any governmental agency other than a state insurance department, or is released by the insurer to the news
17 media, all portions of the confidential memorandum are no longer confidential.

18 (5) For purposes of this section, "qualified actuary" means a member in good standing of the
19 American academy of actuaries who meets the requirements set forth in the academy's rules."

20
21 **Section 14.** Section 33-2-523, MCA, is amended to read:

22 **"33-2-523. Contracts on or after the operative date of 33-20-213 -- valuation.** (1) This section
23 ~~shall apply~~ applies to only those policies and contracts issued on or after the operative date of 33-20-213,
24 except as otherwise provided in 33-2-524 for group annuity and pure endowment contracts issued prior
25 to that date.

26 (2) Except as otherwise provided in 33-2-524, ~~and~~ 33-2-525, and [section 76(2)], the minimum
27 standard for the valuation of all ~~such~~ the policies and contracts issued prior to October 1, 1995, shall must
28 be the standard provided by the laws in effect prior to October 1, 1995. Except as otherwise provided in
29 33-2-524, 33-2-525, and [section 76(2)], the minimum standard for the valuation of all policies and
30 contracts must be the commissioner's reserve valuation methods defined in 33-2-525, ~~and~~ 32-2-526(3);

and (4), and [section 76], 5% interest for group annuity and pure endowment contracts, and 3 1/2% interest for all other ~~such~~ policies and contracts or, in the case of life insurance policies and contracts other than annuity and pure endowment contracts issued on or after March 17, 1973, 4% interest for ~~such~~ all other policies issued prior to July 1, 1979, 5 1/2% interest for single-premium life insurance policies, and 4 1/2% interest for ~~such~~ ALL OTHER policies issued on or after July 1, 1979, and the following tables:

(a) for all ordinary policies of life insurance issued on the standard basis, excluding any disability and accidental death benefits in ~~such~~ the policies;

(i) the commissioner's 1941 standard ordinary mortality table;

~~for~~ for ~~such~~ policies issued prior to the operative date of 33-20-206, as amended, and the commissioner's 1958 standard ordinary mortality table for ~~such~~ policies issued on or after that operative date but prior to January 1, 1989, except that for any category of ~~such~~ the policies issued on female risks, modified net premiums and present values, referred to in 33-2-525 and 33-2-526, may be calculated, at the option of the insurer, with the approval of the commissioner, according to an age younger than the actual age of the insured; or

(ii) for ~~such~~ policies issued on or after January 1, 1989:

(A) the commissioner's 1980 standard ordinary mortality table;

(B) at the election of the company for any one or more specified plans of life insurance, the commissioner's 1980 standard ordinary mortality table with 10-year select mortality factors; or

(C) any ordinary mortality table adopted after 1980 by the national association of insurance commissioners that is approved by the commissioner by rule for use in determining the minimum standard of valuation for ~~such~~ policies;

(b) for all industrial life insurance policies issued on the standard basis, excluding any disability and accidental death benefits in ~~such~~ the policies, the 1941 standard industrial mortality table for ~~such~~ policies issued prior to the operative date of 33-20-207, ~~as amended~~, and, for ~~such~~ policies issued on or after that operative date, the commissioner's 1961 standard industrial mortality table or any industrial mortality table adopted after 1980 by the national association of insurance commissioners that is approved by the commissioner by rule for use in determining the minimum standard of valuation for ~~such~~ the policies;

(c) for individual annuity and pure endowment contracts, excluding any disability and accidental death benefits in ~~such~~ the policies, the 1937 standard annuity mortality table or, at the option of the insurer, the annuity mortality table for 1949, ultimate, or any modification of either of these tables approved

1 by the commissioner;

2 (d) for group annuity and pure endowment contracts, excluding any disability and accidental death
3 benefits in ~~such the~~ policies, the group annuity mortality table for 1951, any modification of ~~such the~~ table
4 approved by the commissioner, or, at the option of the insurer, any of the tables or modifications of tables
5 specified for individual annuity and pure endowment contracts;

6 (e) (i) for total and permanent disability benefits in or supplementary to ordinary policies or
7 contracts:

8 (A) for policies or contracts issued on or after January 1, 1966, the tables of period 2 disablement
9 rates and the 1930 to 1950 termination rates of the 1952 disability study of the society of actuaries, with
10 due regard to the type of benefit, or any tables of disablement rates and termination rates adopted after
11 1980 by the national association of insurance commissioners that are approved by the commissioner by
12 rule for use in determining the minimum standard of valuation for ~~such the~~ policies;

13 (B) for policies or contracts issued on or after January 1, 1961, and prior to January 1, 1966,
14 either ~~such the~~ tables or, at the option of the insurer, the class 3 disability table (1926); and

15 (C) for policies issued prior to January 1, 1961, the class 3 disability table (1926);

16 (ii) any ~~such~~ table ~~shall~~ must, for active lives, be combined with a mortality table permitted for
17 calculating the reserves for life insurance policies;

18 (f) (i) for accidental death benefits in or supplementary to policies:

19 (A) for policies issued on or after January 1, 1966, the 1959 accidental death benefits table or any
20 accidental death benefits table adopted after 1980 by the national association of insurance commissioners
21 that is approved by the commissioner by rule for use in determining the minimum standard of valuation for
22 ~~such the~~ policies;

23 (B) for policies issued on or after January 1, 1961, and prior to January 1, 1966, either such table
24 or, at the option of the insurer, the intercompany double indemnity mortality table; and

25 (C) for policies issued prior to January 1, 1961, the intercompany double indemnity mortality table;

26 (ii) either table ~~shall~~ must be combined with a mortality table permitted for calculating the reserves
27 for life insurance policies;

28 (g) for group life insurance, life insurance issued on the substandard basis, and other special
29 benefits, ~~such the~~ tables as may be approved by the commissioner."

30

1 **Section 15.** Section 33-2-525, MCA, is amended to read:

2 **"33-2-525. Commissioner's reserve valuation method.** (1) Except as otherwise provided in
3 subsection (4) of this section, and 33-2-526(3) and (4), and [section 76(2)], reserves according to the
4 commissioner's reserve valuation method, for the life insurance and endowment benefits of policies
5 providing for a uniform amount of insurance and requiring the payment of uniform premiums, ~~shall~~ must
6 be the excess, if any, of the present value, at the date of valuation, of ~~such~~ future guaranteed benefits
7 provided for by ~~such the~~ policies, over the then present value of any future modified net premiums ~~therefor~~.
8 The modified net premiums for any ~~such~~ policy ~~shall~~ must be ~~such the~~ uniform percentage of the respective
9 contract premiums for ~~such the~~ benefits that the present value, at the date of issue of the policy, of all ~~such~~
10 modified net premiums ~~shall~~ must be equal to the sum of the then present value of ~~such the~~ benefits
11 provided for by the policy and the excess of (a) over (b), as follows:

12 (a) a net level annual premium equal to the present value, at the date of issue, of ~~such~~ benefits
13 provided for after the first policy year, divided by the present value, at the date of issue of an annuity of
14 one per annum payable on the first and each subsequent anniversary of ~~such the~~ policy on which a
15 premium falls due; ~~provided, however~~ However, that such the net level annual premium ~~shall~~ may not
16 exceed the net level annual premium on the 19-year premium whole life plan for insurance of the same
17 amount at an age 1 year higher than the age at issue of ~~such the~~ policy;

18 (b) a net 1-year term premium for ~~such~~ benefits provided for in the first policy year.

19 (2) (a) For ~~every each~~ life insurance policy issued on or after January 1, 1987, for which the
20 contract premium in the first policy year exceeds that of the second year, for which ~~no~~ a comparable
21 additional benefit is not provided in the first year for ~~such the~~ excess, and that provides an endowment
22 benefit, a cash surrender value, or a combination of both in an amount greater than ~~such the~~ excess
23 premium, the reserve according to the commissioner's reserve valuation method, as of any policy
24 anniversary occurring on or before the assumed ending date as the first policy anniversary on which the
25 sum of any endowment benefit and any cash surrender value then available is greater than ~~such the~~ excess
26 premium, is, except as otherwise provided in 33-2-526, the greater of the reserve as of ~~such the~~ policy
27 anniversary calculated as described in subsection (1) or the reserve as of ~~such the~~ policy anniversary
28 calculated as described in subsection (1) with the following exceptions:

29 (i) the value defined in subsection (1)(a) is reduced by 15% of the amount of ~~such the~~ excess
30 first-year premium;

1 (ii) all present values of benefits and premiums are determined without reference to premiums or
2 benefits provided for in the policy after the assumed ending date;

3 (iii) the policy is assumed to mature on ~~such~~ the assumed ending date as an endowment; and

4 (iv) the cash surrender value provided on ~~such~~ the assumed ending date is considered an
5 endowment benefit.

6 (b) In making the comparisons in subsection (2)(a), the mortality and interest bases stated in
7 33-2-523 and 33-2-527 must be used.

8 (3) Reserves according to the commissioner's reserve valuation method for the following ~~shall~~ must
9 be calculated by a method consistent with the principles of this section, except that any extra premiums
10 charged because of impairments or special hazards ~~shall~~ must be disregarded in the determination of
11 modified net premiums:

12 (a) life insurance policies providing for a varying amount of insurance or requiring the payment of
13 varying premiums;

14 (b) group annuity and pure endowment contracts purchased under a retirement plan or plan of
15 deferred compensation, established or maintained by an employer, ~~{including a partnership or sole~~
16 ~~proprietorship}~~, or by an employee organization, or by both, other than a plan providing individual retirement
17 accounts or individual retirement annuities under section 408 of the Internal Revenue Code, as ~~now or~~
18 ~~hereafter~~ amended;

19 (c) disability and accidental death benefits in all policies and contracts; and

20 (d) all other benefits, except life insurance and endowment benefits in life insurance policies and
21 benefits provided by all other annuity and pure endowment contracts.

22 (4) (a) Subsection (4)(b) applies to any annuity and pure endowment contracts other than group
23 annuity and pure endowment contracts purchased under a retirement plan or plan of deferred compensation
24 established or maintained by an employer, ~~{including a partnership or sole proprietorship}~~, or by an
25 employee organization, or by both, other than a plan providing individual retirement accounts or individual
26 retirement annuities under section 408 of the Internal Revenue Code, as ~~now or hereafter~~ amended.

27 (b) Reserves according to the commissioner's annuity reserve method for benefits under annuity
28 or pure endowment contracts, excluding any disability and accidental death benefits in ~~such~~ the contracts,
29 ~~shall~~ must be the greatest of the respective excesses of the present values, at the date of valuation, of the
30 future guaranteed benefits, including guaranteed nonforfeiture benefits, provided for by ~~such~~ the contracts

at the end of each respective contract year, over the present value, at the date of valuation, of any future valuation considerations derived from future gross considerations required by the terms of ~~such the~~ contract that become payable prior to the end of ~~such the~~ respective contract year. The future guaranteed benefits ~~shall must~~ be determined by using the mortality table, if any, and the interest rate or rates specified in ~~such the~~ contracts for determining guaranteed benefits. The valuation considerations are the portions of the respective gross considerations applied under the terms of ~~such the~~ contracts to determine nonforfeiture values."

Section 16. Section 33-2-526, MCA, is amended to read:

"33-2-526. Limits -- options -- minimum reserves. (1) ~~In no event shall an~~ An insurer's aggregate reserves for all life insurance policies, excluding disability and accidental death benefits issued on or after October 1, 1995, may not be less than the aggregate reserves calculated in accordance with the methods set forth in 33-2-525, ~~and~~ subsection (3) of this section, [section 76(2)] and the mortality table or tables and rate or rates of interest used in calculating nonforfeiture benefits for ~~such the~~ policies.

(2) Reserves for all policies and contracts issued prior to October 1, 1995, may be calculated, at the option of the insurer, according to standards that produce greater aggregate reserves for those policies and contracts than the minimum reserves required by the laws in effect immediately prior to October 1, 1995. Reserves for any category of policies, contracts, or benefits as established by the commissioner, issued on or after October 1, 1995, may be calculated at the option of the insurer according to any standards which produce greater aggregate reserves for ~~such a~~ category than those calculated according to the minimum standard ~~herein~~ provided in this section, but the rate or rates of interest used for policies and contracts, other than annuity and pure endowment contracts, ~~shall may~~ not be higher than the corresponding rate or rates of interest used in calculating any nonforfeiture benefits provided for ~~therein~~ a category.

(3) If in any contract year the gross premium charged by any life insurer on any policy or contract is less than the valuation net premium for the policy or contract calculated by the method used in calculating the reserve ~~thereon~~ on the policy or contract but using the minimum valuation standards of mortality and rate of interest, the minimum reserve required for ~~such the~~ policy or contract ~~shall must~~ be the greater of either the reserve calculated according to the mortality table, rate of interest, and method actually used for ~~such the~~ policy or contract or the reserve calculated by the method actually used for ~~such~~

1 the policy or contract but using the minimum standards of mortality and rate of interest and replacing the
 2 valuation net premium by the actual gross premium in each contract year for which the valuation net
 3 premium exceeds the actual gross premium. The minimum valuation standards of mortality and rate of
 4 interest referred to in this section are those standards stated in 33-2-524 and 33-2-527.

5 (4) For every life insurance policy issued after December 30, 1986, for which the gross premium
 6 in the first policy year exceeds that of the second year, for which ~~no~~ a comparable additional benefit is not
 7 provided in the first year for ~~such~~ an excess, and that provides an endowment benefit, a cash surrender
 8 value, or a combination of both in an amount greater than ~~such~~ the excess premium, subsections (1)
 9 through (3) of this section must be applied as if the method actually used in calculating the reserve for ~~such~~
 10 the policy were the method described in 33-2-525(1). The minimum reserve at each policy anniversary of
 11 ~~such a~~ the policy must be the greater of the minimum reserve calculated in accordance with 33-2-525 and
 12 the minimum reserve calculated in accordance with this section."

13
 14 **Section 17.** Section 33-2-528, MCA, is amended to read:

15 **"33-2-528. Interest rate weighting factor.** (1) The weighting factors referred to in the formulas
 16 stated in 33-2-527 are as follows:

17 (a) (i) for life insurance:

18 Guarantee Duration in Years	19 Weighting Factors
20 10 or less	.50
21 More than 10 but not more than 20	.45
22 More than 20	.35

23 (ii) for life insurance, the guarantee duration is the maximum number of years the life insurance can
 24 remain in force on a basis guaranteed in the policy or under options to convert to plans of life insurance
 25 with premium rates or nonforfeiture values, or both, that are guaranteed in the original policy;

26 (b) .80 for single premium immediate annuities and for annuity benefits involving life contingencies
 27 arising from other annuities with cash settlement options and guaranteed interest contracts with cash
 28 settlement options;

29 (c) for other annuities and for guaranteed interest contracts, except as stated in subsection (1)(b),
 30 according to the guarantee duration established in ~~subsection (2)~~ subsections (1)(c)(i) through (1)(c)(iii) and

1 the ~~type of plan~~ rules and definitions established in established in ~~subsection~~ subsections (2), (3), and (4):

2 (i) for annuities and guaranteed interest contracts valued on an issue year basis:

3 Guarantee Duration in Years	4 Weighting Factor		
	5 for Plan Type		
	A	B	C
6 5 or less	.80	.60	.50
7 More than 5 but not more than 10	.75	.60	.50
8 More than 10 but not more than 20	.65	.50	.45
9 More than 20	.45	.35	.35

10	11 Plan Type		
	A	B	C

11 (ii)

12 for annuities and guaranteed interest contracts valued on a

13 change-in-fund basis, the factors shown in subsection (1)(c)(i)

14 increased by:

15	16 Plan Type		
	A	B	C

16 (iii)

17 for annuities and guaranteed interest contracts valued on

18 an issue year basis, ~~other than those with no~~ without cash

19 settlement options}, that do not guarantee interest on

20 considerations received more than 1 year after issue or purchase

21 and for annuities and guaranteed interest contracts valued on a

22 change-in-fund basis that do not guarantee interest rates on

23 considerations received more than 12 months beyond the valuation

24 date, the factors set forth in subsection (1)(c)(i) or derived in

25 subsection (1)(c)(ii) increased by:

26 (2) For other annuities with cash settlement options and guaranteed interest contracts with cash
27 settlement options, the guarantee duration is the number of years for which the contract guarantees interest
28 rates in excess of the calendar year statutory valuation interest rate for life insurance policies with
29 guarantee duration in excess of 20 years. For other annuities ~~with no~~ without cash settlement options and
30 for guaranteed interest contracts ~~with no~~ without cash settlement options, the guarantee duration is the

1 number of years from the date of issue or date of purchase to the date annuity benefits are scheduled to
2 commence.

3 (3) Plan types used in subsection (1)(c) are:

4 (a) Plan Type A--No withdrawal is permitted or at any time policyholder may withdraw funds only:

5 (i) with an adjustment to reflect changes in interest rates or asset values since receipt of the funds
6 by the insurance company;

7 (ii) without ~~such an~~ adjustment but in installments over 5 years or more; or

8 (iii) as an immediate life annuity.

9 (b) Plan Type B--(i) Before expiration of the interest rate guarantee, no withdrawal is permitted or
10 a policyholder may withdraw funds only:

11 (A) with an adjustment to reflect changes in interest rates or asset values since receipt of the funds
12 by the insurance company;

13 (B) without ~~such an~~ adjustment but in installments over 5 years or more.

14 (ii) At the end of the interest rate guarantee, funds may be withdrawn without ~~such an~~ adjustment
15 in a single sum or installments over less than 5 years.

16 (c) Plan Type C--A policyholder may withdraw funds before expiration of the interest rate guarantee
17 in a single sum or installments over less than 5 years either:

18 (i) without adjustment to reflect changes in interest rates or asset values since receipt of the funds
19 by the insurance company; or

20 (ii) subject only to a fixed surrender charge stipulated in the contract as a percentage of the fund.

21 (4) (a) An insurer may elect to value guaranteed interest contracts with cash settlement options
22 and annuities with cash settlement options on either an issue year basis or on a change-in-fund basis.
23 Guaranteed interest contracts ~~with no~~ without cash settlement options and other annuities ~~with no~~ without
24 cash settlement options must be valued on an issue year basis.

25 (b) As used in subsection (4):

26 (i) issue year basis of valuation is a valuation basis under which the interest rate used to determine
27 the minimum valuation standard for the entire duration of the annuity or guaranteed interest contract is the
28 calendar year valuation interest rate for the year of issue or year of purchase of the annuity or guaranteed
29 interest contract; and

30 (ii) change-in-fund basis of valuation is a valuation basis under which the interest rate used to

determine the minimum valuation standard applicable to each change in the fund held under the annuity or guaranteed interest contract is the calendar year valuation interest rate for the year of the change in the fund."

Section 18. Section 33-2-529, MCA, is amended to read:

"33-2-529. Reference interest rate. (1) The reference interest rate referred to in the formulas in 33-2-527 is:

(a) for all life insurance, the lesser of the average over a period of 36 months and the average over a period of 12 months, ending on June 30 of the calendar year next preceding the year of issue, of Moody's ~~corporate bond yield average~~—monthly average ~~corporate~~ composite yield on seasoned corporate bonds;

(b) for single-premium immediate annuities and for annuity benefits involving life contingencies arising from other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, the average over a period of 12 months, ending on June 30 of the calendar year of issue or purchase, of Moody's ~~corporate bond yield average~~—monthly average ~~corporate~~ composite yield on seasoned corporate bonds;

(c) for other annuities with cash settlement options and guaranteed interest contracts with cash settlement options valued on a year-of-issue basis, except as stated in subsection (1)(b), with guarantee duration in excess of 10 years, the lesser of the average over a period of 36 months and the average over a period of 12 months, ending on June 30 of the calendar year of issue or purchase, of Moody's ~~corporate bond yield average~~—monthly average ~~corporate~~ composite yield on seasoned corporate bonds;

(d) for other annuities with cash settlement options and guaranteed interest contracts with cash settlement options valued on a year-of-issue basis, except as stated in subsection (1)(b), with guarantee duration of 10 years or less, the average over a period of 12 months, ending on June 30 of the calendar year of issue or purchase, of Moody's ~~corporate bond yield average~~—monthly average ~~corporate~~ composite yield on seasoned corporate bonds;

(e) for other annuities ~~with no~~ without cash settlement options and for guaranteed interest contracts ~~with no~~ without cash settlement options, the average over a period of 12 months, ending on June 30 of the calendar year of issue or purchase, of Moody's ~~corporate bond yield average~~—monthly average ~~corporate~~ composite yield on seasoned corporate bonds; or

(f) for other annuities with cash settlement options and guaranteed interest contracts with cash settlement options valued on a change-in-fund basis, except as stated in subsection (1)(b), the average over a period of 12 months, ending on June 30 of the calendar year of the change in the fund, of Moody's ~~corporate bond yield average~~ monthly average ~~corporate~~ composite yield on seasoned corporate bonds.

(2) If Moody's ~~corporate bond yield average~~ monthly average ~~corporate~~ composite yield on seasoned corporate bonds is no longer published by Moody's investors service, inc., or if the national association of insurance commissioners determines that Moody's ~~corporate bond yield average~~ monthly average ~~corporate~~ composite yield on seasoned corporate bonds, as published by Moody's investors service, inc., is no longer appropriate for the determination of the reference interest rate, then an alternative method for determination of the reference interest rate adopted by the national association of insurance commissioners and approved by rule promulgated by the commissioner may be substituted."

Section 19. Section 33-2-531, MCA, is amended to read:

"33-2-531. Deposit of reserves -- domestic life insurers. (1) Domestic life insurers shall deposit and maintain on deposit, in securities and assets, with depositaries and subject to conditions as provided for in part 6 of this chapter, an amount not less than the reserves on its outstanding life insurance policies and annuity contracts, as valued under 33-2-521 through 33-2-526, minus policy loans.

(2) Annually on or before April 1, the insurer shall ~~se~~ deposit any additional ~~such~~ securities or assets required under subsection (1) and related to the increase of ~~such the~~ reserves, minus policy loans, during the calendar year next preceding, as determined from the insurer's annual statement as at December 31 of ~~such the~~ preceding year.

(3) A domestic stock life insurer may credit toward ~~such the~~ deposit the amount of any other deposit of the insurer held under part 6 of this chapter for the protection of its policyholders or of its policyholders and creditors.

(4) Deposits of the reserves of a domestic life insurer under this section ~~shall~~ must consist of securities and assets acquired and valued in accordance with parts 5 and 8 of this chapter.

(5) Real estate mortgage loans, and chattel mortgage loans, ~~and policy loans~~ may be made a part of the deposit by filing a verified statement of the loans with the commissioner, ~~which statement shall be~~. The statement is subject to audit at all times by the commissioner. Nonnegotiable securities ~~where~~ deposited with the commissioner ~~shall~~ must be accompanied by transfer powers in due form. If the insurer

1 uses real estate acquired under 33-2-832 as a deposit, then a deed of trust, mortgage, or other instrument
2 sufficient to convey a security interest in ~~such the~~ real estate, in a form acceptable to the commissioner,
3 ~~shall~~ must be completed in due form and recorded prior to being deposited with the commissioner.

4 (6) If default occurs in the payment of interest or principal of any deposited security and ~~such the~~
5 default continues for a period of 120 days, the commissioner may declare ~~such the~~ security no longer
6 eligible for deposit under this section."

7
8 **Section 20.** Section 33-2-701, MCA, is amended to read:

9 **"33-2-701. Annual statement -- revocation or fine for failure to file -- penalty for perjury.** (1) Each
10 authorized insurer shall annually on or before March 1 file with the commissioner a full and true statement
11 of its financial condition, transactions, and affairs as of the preceding December 31 ~~preceding~~. The
12 statement must be in the general form and context as is required or not disapproved by the commissioner,
13 as is in current use for similar reports to states in general with respect to the type of insurer and kinds of
14 insurance to be reported upon, and as supplemented for additional information required by the
15 commissioner. The statement must be completed in accordance with the annual statement instructions and
16 the accounting practices and procedures manual of the national association of insurance commissioners.
17 The statement must be accompanied by an actuarial opinion attesting to the adequacy of the insurer's
18 reserves. The statement must be verified by the oath of the insurer's president or vice-president and
19 secretary or, if a reciprocal insurer, by the oath of the attorney-in-fact or its like officers if a corporation.
20 The commissioner may waive the verification under oath.

21 (2) (a) Each domestic insurer shall file electronic diskette versions of its annual and quarterly
22 financial statements with the national association of insurance commissioners. The filing date for
23 submission of the annual statement diskette is March 1. The filing dates for the quarterly statement
24 diskettes are as follows:

25 (i) the first calendar quarter filing is due May 15;

26 (ii) the second calendar quarter filing is due August 15; and

27 (iii) the third calendar quarter filing is due November 15.

28 (b) The commissioner may exempt insurers that operate only in Montana from these filing
29 requirements.

30 (2)(3) The statement of an alien insurer must relate only to its transactions and affairs in the United

1 States unless the commissioner requires otherwise. If the commissioner requires a statement as to an alien
2 insurer's affairs throughout the world, the insurer shall file the statement with the commissioner as soon
3 as reasonably possible. The statement must be verified by the insurer's United States manager or other
4 authorized officer.

5 ~~(3)~~(4) The commissioner may refuse to accept the fee for continuance of the insurer's certificate
6 of authority, as provided in 33-2-117, or may suspend or revoke the certificate of authority of any insurer
7 failing to file its annual statement when due or within an extension of time that the commissioner may
8 grant.

9 ~~(4)~~(5) Any director, officer or insurance producer, or employee of any company who subscribes
10 to, makes, or concurs in making or publishing any annual statement or any other statement required by law
11 knowing that the same to contain statement contains any material statement which is false shall be
12 punished by a fine of not more than \$1,000.

13 ~~(5)~~(6) At time of filing, the insurer shall pay to the commissioner the fee for filing its statement as
14 prescribed in 33-2-708.

15 ~~(6)~~(7) The commissioner may impose a fine not to exceed \$100 a day for each day after March
16 1 that an insurer fails to file the annual statement referred to in subsection (1). The fine may not exceed
17 a maximum of \$1,000."

18
19 **Section 21.** Section 33-2-705, MCA, is amended to read:

20 **"33-2-705. Report on premiums and other consideration -- tax.** (1) Each authorized insurer and
21 each formerly authorized insurer with respect to premiums received while an authorized insurer in this state
22 shall file with the commissioner, on or before March 1 each year, a report in a form prescribed by the
23 commissioner showing total direct premium income, including policy, membership, and other fees,
24 premiums paid by application of dividends, refunds, savings, savings coupons, and similar returns or credits
25 to payment of premiums for new or additional or extended or renewed insurance, charges for payment of
26 premium in installments, and all other consideration for insurance from all kinds and classes of insurance,
27 whether designated as a premium or otherwise, received by a life insurer or written by an insurer other than
28 a life insurer during the preceding calendar year on account of policies covering property, subjects, or risks
29 located, resident, or to be performed in Montana, with proper proportionate allocation of premium as to
30 property, subjects, or risks in Montana insured under policies or contracts covering property, subjects, or

1 risks located or resident in more than one state, after deducting from the total direct premium income
2 applicable cancellations, returned premiums, the unabsorbed portion of any deposit premium, the amount
3 of reduction in or refund of premiums allowed to industrial life policyholders for payment of premiums direct
4 to an office of the insurer, all policy dividends, refunds, savings, savings coupons, and other similar returns
5 paid or credited to policyholders with respect to the policies. As to title insurance, "premium" includes the
6 total charge for the insurance. A deduction may not be made of the cash surrender values of policies.
7 Considerations received on annuity contracts may not be included in total direct premium income and are
8 not subject to tax.

9 (2) Coincident with the filing of the tax report referred to in subsection (1), each insurer shall pay
10 to the commissioner a tax upon the net premiums computed at the rate of 2 3/4%.

11 (3) That portion of the tax paid under this section by an insurer on account of premiums received
12 for fire insurance must be separately specified in the report as required by the commissioner, for
13 apportionment as provided by law. When insurance against fire is included with insurance of property
14 against other perils at an undivided premium, the insurer shall make a reasonable allocation from the entire
15 premium to the fire portion of the coverage as must be stated in the report and as may be approved or
16 accepted by the commissioner.

17 (4) With respect to authorized insurers, the premium tax provided by this section must be payment
18 in full and in lieu of all other demands for any and all state, county, city, district, municipal, and school
19 taxes, licenses, fees, and excises of whatever kind or character, excepting only those prescribed by this
20 code, taxes on real and tangible personal property located in this state, and taxes payable under 50-3-109.

21 (5) The commissioner may suspend or revoke the certificate of authority of any insurer ~~which~~ that
22 fails to pay its taxes as required under this section.

23 (6) In addition to the penalty provided for in subsection (5), the commissioner may impose upon
24 an insurer who fails to pay the tax required under this section a fine of \$100 plus interest on the delinquent
25 amount at the annual interest rate ~~established in 31-1-107~~ of 12%.

26 (7) The commissioner may by rule provide a quarterly schedule for payment of portions of the
27 premium tax under this section during the year in which tax liability is accrued."
28

29 **Section 22.** Section 33-2-708, MCA, is amended to read:

30 **"33-2-708. Fees and licenses.** (1) Except as provided in 33-17-212(2), the commissioner shall

1 collect in advance and the persons served shall pay to the commissioner the following fees:

2 (a) certificates of authority:

3 (i) for filing applications for original certificates of authority, articles of incorporation, ~~except~~
4 original articles of incorporation of domestic insurers as provided in subsection (1)(b), and other charter
5 documents, bylaws, financial statement, examination report, power of attorney to the commissioner, and
6 all other documents and filings required in connection with the application and for issuance of an original
7 certificate of authority, if issued:

8 (A) domestic insurers \$ 600.00

9 (B) foreign insurers 600.00

10 (ii) annual continuation of certificate of authority 600.00

11 (iii) reinstatement of certificate of authority 25.00

12 (iv) amendment of certificate of authority 50.00

13 (b) articles of incorporation:

14 (i) filing original articles of incorporation of a domestic insurer, exclusive of fees required to be paid
15 by the corporation to the secretary of state 20.00

16 (ii) filing amendment of articles of incorporation, domestic and foreign insurers, exclusive of fees
17 required to be paid to the secretary of state by a domestic corporation 25.00

18 (c) filing bylaws or amendment to bylaws when required 10.00

19 (d) filing annual statement of insurer, other than as part of application for original certificate of
20 authority 25.00

21 (e) insurance producer's license:

22 (i) application for original license, including issuance of license, if issued 15.00

23 (ii) appointment of insurance producer, each insurer, electronically filed 10.00

24 (iii) appointment of insurance producer, each insurer, nonelectronically filed 15.00

25 (iv) temporary license 15.00

26 (v) amendment of license, ~~excluding additions to license~~, or reissuance of master license 15.00

27 (vi) termination of insurance producer, each insurer, electronically filed 10.00

28 (vii) termination of insurance producer, each insurer, nonelectronically filed 15.00

29 (f) nonresident insurance producer's license:

30 (i) application for original license, including issuance of license, if issued 100.00

1	(ii) appointment of insurance producer, each insurer, electronically filed	10.00
2	(iii) appointment of insurance producer, each insurer, nonelectronically filed	15.00
3	(iv) annual renewal of license	10.00
4	(v) amendment of license, excluding additions to license , or reissuance of master license	15.00
5	(vi) termination of insurance producer, each insurer, electronically filed	10.00
6	(vii) termination of insurance producer, each insurer, nonelectronically filed	15.00
7	(g) examination, if administered by the commissioner, for license as insurance producer, each	
8	examination	15.00
9	(h) surplus lines insurance producer license:	
10	(i) application for original license and for issuance of license, if issued	50.00
11	(ii) annual renewal of license	50.00
12	(i) adjuster's license:	
13	(i) application for original license and for issuance of license, if issued	15.00
14	(ii) annual renewal of license	15.00
15	(j) insurance vending machine license, each machine, each year	10.00
16	<u>(k) motor club representative's license:</u>	
17	<u>(i) application for original license and issuance of license, if issued</u>	<u>15.00</u>
18	<u>(ii) annual renewal of license</u>	<u>15.00</u>
19	(l) <u>(l)</u> commissioner's certificate under seal, except when on certificates of authority or	
20	licenses	10.00
21	(m) <u>(m)</u> copies of documents on file in the commissioner's office, per page	.50
22	(n) <u>(n)</u> policy forms:	
23	(i) filing each policy form	25.00
24	(ii) filing each application, certificate, enrollment form, rider, endorsement, amendment, insert page,	
25	schedule of rates, and clarification of risks	10.00
26	(iii) maximum charge if policy and all forms submitted at one time or resubmitted for approval within	
27	180 days, <u>provided that all additional forms relate to the same policy</u>	100.00
28	(o) <u>(o)</u> applications for approval of prelicensing education courses:	
29	(i) reviewing initial application	150.00
30	(ii) periodic review	50.00

(2) The commissioner shall establish by rule fees commensurate with costs for filing documents and conducting the course reviews required by 33-17-1204 and 33-17-1205.

(3) The commissioner shall establish by rule an annual accreditation fee to be paid by each domestic and foreign insurer when it submits a fee for annual continuation of its certificate of authority.

(4)(a) Except as provided in subsection (4)(b), the commissioner shall promptly deposit with the state treasurer to the credit of the general fund of this state all fines and penalties, those amounts received pursuant to 33-2-311, 33-2-705, and 33-2-706, and any fees and examination and miscellaneous charges that are collected by the commissioner pursuant to Title 33 and the rules adopted under Title 33, except that all fees for filing documents and conducting the course reviews required by 33-17-1204 and 33-17-1205 must be deposited in the state special revenue fund pursuant to 33-17-1207.

(b) The accreditation fee required by subsection (3) must be turned over promptly to the state treasurer who shall deposit the money in the state special revenue fund to the credit of the commissioner's office. The accreditation fee funds must be used only to pay the expenses of the commissioner's office in discharging the administrative and regulatory duties that are required to meet the minimum financial regulatory standards established by the national association of insurance commissioners, subject to the applicable laws relating to the appropriation of state funds and to the deposit and expenditure of money. The commissioner is responsible for the proper expenditure of the accreditation money.

(5) All fees are considered fully earned when received. In the event of overpayment, only those amounts in excess of \$10 will be refunded."

Section 23. Section 33-2-803, MCA, is amended to read:

"33-2-803. General qualifications of investments. (1) ~~No A~~ security or investment, other than real and personal property acquired under 33-2-832, ~~shall be~~ is not eligible for acquisition unless it is interest bearing or interest accruing or dividend or income paying, if not then in default in any respect, and the insurer is entitled to receive for its exclusive account and benefit the interest or income accruing ~~thereon~~ on the security or investment. However, up to 3% of a company's total assets may be invested in nondividend-paying common stock as described in 33-2-820.

(2) ~~No A~~ security or investment ~~shall be~~ is not eligible for purchase at a price above its market value.

(3) ~~No A~~ provision of this part ~~shall~~ may not prohibit the acquisition by an insurer of other or

1 additional securities or property if received as a dividend or as a lawful distribution of assets or under a
2 lawful and bona fide agreement of bulk reinsurance, merger, or consolidation. Any investment ~~so~~ acquired
3 ~~which that~~ is not otherwise eligible under this part ~~shall~~ must be disposed of pursuant to 33-2-842 if
4 personal property or securities or pursuant to 33-2-841 if real property."

5
6 **Section 24.** Section 33-2-806, MCA, is amended to read:

7 **"33-2-806. Diversification of investments.** An insurer shall invest in or hold as admitted assets
8 categories of investments only within applicable limits as follows:

9 (1) An insurer ~~shall~~ may not, except with the consent of the commissioner, have at any one time
10 any combination of investments in or loans upon the security of the obligations, property, or securities of
11 any one person or insurer aggregating an amount exceeding 5% of the insurer's assets. This restriction ~~shall~~
12 does not apply as to general obligations of the United States of America or of any state or include policy
13 loans made under 33-2-825.

14 (2) An insurer ~~shall~~ may not invest in or hold at any one time more than 10% of the outstanding
15 voting stock of any corporation, except with the consent of the commissioner given with respect to voting
16 rights of preference stock during default of dividends. This provision does not apply as to stock of a
17 wholly-owned subsidiary of the insurer or to controlling stock of an insurer acquired under 33-2-821.

18 (3) An insurer, other than title insurer, shall invest and maintain invested funds not less in amount
19 than the minimum paid-in capital stock required under this code of a domestic stock insurer transacting like
20 kinds of insurance, only in cash and the securities provided for under the following sections: 33-2-811(1),
21 33-2-812, and 33-2-830.

22 (4) A life insurer shall also invest and keep invested its funds in an amount not less than the
23 reserves under its life insurance policies and annuity contracts, other than variable annuities, in force in
24 cash, ~~and/or the in securities, in both cash and securities,~~ or in investments provided for under 33-2-531.

25 (5) Except with the commissioner's consent, an insurer ~~shall~~ may not have invested at any one
26 time more than 20% of its assets in the class of securities described in 33-2-818, exclusive of obligations
27 of public utilities.

28 (6) An insurer may not invest and have invested at any one time in aggregate amount ~~not~~ more
29 than ~~40%~~ 15% of its assets in all stocks under 33-2-820 and 33-2-821. Determination of the amount
30 ~~which that~~ an insurer has invested in common stocks for the purposes of this provision ~~shall~~ must be based

1 on the cost of ~~such~~ the stocks to the insurer. This provision ~~shall~~ does not apply as to stock of a controlled
2 or subsidiary insurance corporation or other corporations under 33-2-821 and 33-2-822.

3 (7) Except with the commissioner's consent, an insurer may not have invested at any one time
4 more than 5% of its assets in securities allowed under 33-2-824.

5 (8) Except with the commissioner's consent, an insurer ~~shall~~ may not have invested at any one
6 time more than 10% of its assets in the class of securities described in any one of the following sections:
7 33-2-814, 33-2-819, and 33-2-823.

8 (9) Limits as to investments in the category of real estate shall be as provided in 33-2-832. Other
9 specific limits ~~shall~~ apply as stated in the sections dealing with other respective kinds of investments."

10
11 **Section 25.** Section 33-2-820, MCA, is amended to read:

12 "**33-2-820. Common stocks.** An insurer may invest in nonassessable common stocks, other than
13 insurance stocks, of any solvent corporation existing under the laws of the United States of America or of
14 Canada or any state or province thereof ~~if cash or stock dividends have been earned and paid on its~~
15 ~~common stock in each of the 5 fiscal years preceding such acquisition and if, further, all prior obligations~~
16 ~~or preference stock of such corporation, if any, are eligible for investment under this part. If the issuing~~
17 ~~corporation has not been in legal existence for the whole of the 5 preceding fiscal years but was formed~~
18 ~~as a consolidation or merger of two or more businesses, the test of eligibility for investment of its common~~
19 ~~stock under this section shall be based upon consolidation pro forma statements of the predecessor or~~
20 ~~constituent institutions."~~

21
22 **Section 26.** Section 33-2-1111, MCA, is amended to read:

23 "**33-2-1111. Registration of insurers -- requisites -- termination.** (1) ~~Every~~ An insurer ~~which is~~
24 authorized to do business in this state ~~and which~~ that is a member of an insurance holding company system
25 shall register with the commissioner, except that a foreign insurer subject to disclosure requirements and
26 standards adopted by statute or regulation in the jurisdiction of its domicile ~~which~~ that are substantially
27 similar to those contained in this section is not required to register. Any insurer ~~which is~~ subject to
28 registration under this section shall register within 15 days after it ~~becomes~~ becoming subject to
29 registration, unless the commissioner for good cause ~~shown~~ extends the time for registration, ~~and then~~
30 ~~within the extended time.~~ The commissioner may require any authorized insurer ~~which~~ that is a member

1 of a holding company system ~~which~~ that is not subject to registration under this section to furnish a copy
2 of the registration statement or other information filed by the insurance company with the insurance
3 regulatory authority ~~of domiciliary in the jurisdiction~~ where the company is domiciled.

4 (2) ~~Every~~ An insurer subject to registration shall file with the commissioner, on or before April 30
5 each year, a registration statement on a form provided by the commissioner, ~~which~~ that must contain
6 current information about:

7 (a) the capital structure, general financial condition, ownership, and management of the insurer and
8 any person controlling the insurer;

9 (b) the identity of every member of the insurance holding company system;

10 (c) ~~the following agreements in force, existing relationships subsisting, and~~ transactions currently
11 outstanding between the insurer and its affiliates, and the following agreements that are in force:

12 (i) loans, other investments, or purchases, sales, or exchanges of securities of the affiliates by the
13 insurer or of the insurer by its affiliates;

14 (ii) purchases, sales, or exchanges of assets;

15 (iii) transactions not in the ordinary course of business;

16 (iv) guaranties or undertakings for the benefit of an affiliate ~~which~~ that result in an actual
17 contingent exposure of the insurer's assets to liability, other than insurance contracts entered into in the
18 ordinary course of the insurer's business;

19 (v) ~~all~~ management and service contracts and ~~all~~ cost-sharing arrangements, ~~other than cost~~
20 ~~allocation arrangements based upon generally accepted accounting principles~~;

21 (vi) reinsurance agreements covering all or substantially all of one or more lines of insurance of the
22 ceding company;

23 (vii) dividends and other distributions to shareholders; and

24 (viii) consolidated tax allocation agreements;

25 (d) ~~any~~ a pledge of the insurer's stock, including stock of a subsidiary or controlling affiliate for a
26 loan made to a member of the insurance holding company system;

27 (e) all matters concerning transactions between registered insurers and any affiliates as may be
28 included from time to time in ~~any~~ registration forms adopted or approved by the commissioner.

29 (3) A registration statement must contain a summary outlining each item in the current registration
30 statement that represents a change from the prior registration statement.

(4) Information need not be disclosed on the registration statement filed pursuant to subsection (2) if the information is not material for the purposes of this section. Unless the commissioner by rule or order provides otherwise, sales, purchases, exchanges, loans or extensions of credit, or investments involving 1/2 of 1% or less of an insurer's admitted assets as of the prior December 31 ~~next preceding~~ are not material for purposes of this section.

(5) A person within an insurance holding company system subject to registration shall provide complete and accurate information to an insurer if the information is reasonably necessary to enable the insurer to comply with Title 33, chapter 2, part 11.

(6) Each registered insurer shall keep current the information required to be disclosed in its registration statement by reporting all material changes or additions on amendment forms provided by the commissioner within 15 days after the end of the month in which it learns of each change or addition.

(7) The commissioner shall terminate the registration of any insurer ~~which~~ that demonstrates that it no longer is a member of an insurance holding company system.

(8) The commissioner may require or allow two or more affiliated insurers subject to registration under this section to file a consolidated registration statement or consolidated reports amending their consolidated registration statement or their individual registration statements.

(9) The commissioner may allow an insurer ~~which~~ that is authorized to do business in this state and ~~which~~ that is part of an insurance holding company system to register on behalf of any affiliated insurer which is required to register under subsection (1) and to file all information and material required to be filed under this section."

Section 27. Section 33-2-1201, MCA, is amended to read:

"33-2-1201. Limit of risk. (1) An insurer may not retain any risk on any one subject of insurance, whether located or to be performed in this state or elsewhere, in an amount exceeding 10% of its surplus to policyholders.

(2) A "subject of insurance" for the purposes of this section, as to insurance against fire and hazards other than windstorm, earthquake, or other catastrophe hazards, includes all properties insured by the same insurer which are customarily considered by underwriters to be subject to loss or damage from the same fire or the same occurrence of the other hazard insured against.

(3) Reinsurance ceded as authorized by this part must be deducted in determining risk retained.

As to surety risks, deduction must also be made of the amount assumed by any established incorporated cosurety and the value of any security deposited, pledged, or held subject to the surety's consent and for the surety's protection.

(4) As to alien insurers, this section only relates to risks and surplus to policyholders of the insurer's United States branch.

(5) "Surplus to policyholders" for the purposes of this section, in addition to the insurer's capital and surplus, is considered to include any voluntary reserves which are not required pursuant to law and are determined from the last sworn statement of the insurer on file with the commissioner or by the last report of examination of the insurer, whichever is the more recent at time of assumption of risk.

(6) This section does not apply to life or disability insurance, title insurance, insurance of wet marine and transportation risks, workers' compensation insurance, employer's liability coverages, ~~sprinklered risks~~, or any policy or type of coverage as to which the maximum possible loss to the insurer is not readily ascertainable on issuance of the policy."

Section 28. Section 33-2-1216, MCA, is amended to read:

"33-2-1216. Credit allowed domestic ceding insurer. (1) Credit for reinsurance is allowed to a domestic ceding insurer as either an asset or a deduction from liability on account of reinsurance ceded only when the reinsurer meets the requirements of subsection (2), (3), (4), (5), or (6). If the requirements of subsection (4) or (5) are met, the requirements of subsection (7) must also be met.

(2) Credit must be allowed when the reinsurance is ceded to an assuming insurer that is licensed to transact insurance or reinsurance in this state.

(3) Credit must be allowed when the reinsurance is ceded to an assuming insurer that is accredited as a reinsurer in this state. Credit may not be allowed a domestic ceding insurer if the assuming insurer's accreditation has been revoked by the commissioner after notice and hearing. An accredited reinsurer is one that:

(a) files with the commissioner evidence of its submission to this state's jurisdiction;

(b) submits to this state's authority to examine its books and records;

(c) is licensed to transact insurance or reinsurance in at least one state or, in the case of a United States branch of an alien assuming insurer, is entered through and licensed to transact insurance or reinsurance in at least one state;

(d) files annually with the commissioner a copy of its annual statement filed with the insurance department of its state of domicile and a copy of its most recent audited financial statement and either:

(i) maintains a surplus with regard to policyholders in an amount that is not less than \$20 million and whose accreditation has not been denied by the commissioner within 90 days of its submission; or

(ii) maintains a surplus with regard to policyholders in an amount less than \$20 million and whose accreditation has been approved by the commissioner.

(4) (a) Subject to subsection (4)(b), credit must be allowed when:

(i) the reinsurance is ceded to an assuming insurer that is domiciled and licensed in or, in the case of a United States branch of an alien assuming insurer, is entered through a state that employs standards regarding credit for reinsurance substantially similar to those applicable under this statute; and

(ii) the assuming insurer or the United States branch of an alien assuming insurer:

(A) maintains a surplus with regard to policyholders in an amount not less than \$20 million; and

(B) submits to the authority of this state to examine its books and records.

(b) The requirement of subsection (4)(a)(i) does not apply to reinsurance ceded and assumed pursuant to pooling arrangements among insurers in the same holding company system.

(5) (a) Credit must be allowed when the reinsurance is ceded to an assuming insurer that maintains a trust fund in a qualified United States financial institution for the payment of the valid claims of its United States policyholders and ceding insurers and their assigns and successors in interest. The assuming insurer shall report annually to the commissioner information substantially the same as that required to be reported on the NAIC annual statement form by licensed insurers to enable the commissioner to determine the sufficiency of the trust fund.

(b) (i) In the case of a single assuming insurer, the trust must consist of a trust account representing the assuming insurer's liabilities attributable to business written in the United States, and in addition, the assuming insurer shall maintain a surplus with the trustee of not less than \$20 million.

(ii) In the case of a group, ~~of~~ including incorporated and individual unincorporated underwriters, the trust must consist of a trust account representing the group's liabilities attributable to business written in the United States, and in addition, the group shall maintain a surplus with the trustee of which \$100 million must be held jointly for the benefit of United States ceding insurers of any member of the group.

(iii) The incorporated members of the group, as group members, may not be engaged in a business

1 other than underwriting as members of the group and are subject to the same level of solvency regulation
2 and control by the insurance regulator as the unincorporated members. The group shall make available to
3 the commissioner an annual certification of the solvency of each underwriter by the ~~group's domiciliary~~
4 insurance regulator and the independent public accountants in the jurisdiction where the underwriter is
5 domiciled and its independent public accountants.

6 ~~(iii)(iv)~~ In the case of a group of incorporated insurers under common administration:

7 (A) the provisions of subsection ~~(5)(b)(iii)(B)~~ (5)(b)(iv)(B) apply to the group that:

8 (I) complies with the reporting requirements contained in subsection (5)(a);

9 (II) has continuously transacted an insurance business outside the United States for at least 3 years
10 immediately prior to making application for accreditation;

11 (III) submits to this state's authority to examine its books and records and bears the expense of the
12 examination; and

13 (IV) has aggregate policyholders' surplus of \$10 billion;

14 (B) (I) the trust must be in an amount equal to the group's several liabilities attributable to business
15 ceded by United States ceding insurers to any member of the group pursuant to reinsurance contracts
16 issued in the name of the group;

17 (II) the group shall maintain a joint surplus with a trustee of which \$100 million is held jointly for
18 the benefit of United States ceding insurers of any member of the group as additional security for any
19 liabilities; and

20 (III) each member of the group shall make available to the commissioner an annual certification of
21 the member's solvency by the ~~member's domiciliary regulator and its independent public accountant~~
22 insurance regulator and the independent public accountants in the jurisdiction where the underwriter is
23 domiciled.

24 (c) The trust must be established in a form approved by the commissioner. The trust instrument
25 must provide that contested claims are valid and enforceable upon the final order of any court of competent
26 jurisdiction in the United States. The trust must vest legal title to its assets in the trustees of the trust for
27 its United States policyholders and ceding insurers and their assigns and successors in interest. The trust
28 and the assuming insurer are subject to examination as determined by the commissioner. The trust
29 described in this subsection (c) must remain in effect for as long as the assuming insurer has outstanding
30 obligations due under the reinsurance agreements subject to the trust.

(d) No later than February 28 of each year, the trustees of the trust shall report to the commissioner in writing setting forth the balance of the trust and listing the trust's investments at the end of the preceding year. The trustees shall certify the date of termination of the trust, if planned, or certify that the trust may not expire prior to the following December 31.

(6) Credit must be allowed when the reinsurance is ceded to an assuming insurer that does not meet the requirements of subsection (2), (3), (4), or (5) but only with respect to the insurance of risks located in a jurisdiction in which the reinsurance is required by applicable law or regulation of that jurisdiction.

(7) (a) If the assuming insurer is not licensed or accredited to transact insurance or reinsurance in this state, the credit permitted by subsections (4) and (5) may not be allowed unless the assuming insurer agrees in the reinsurance agreements:

(i) that in the event of the failure of the assuming insurer to perform its obligations under the terms of the reinsurance agreement, the assuming insurer, at the request of the ceding insurer, will:

(A) submit to the jurisdiction of any court of competent jurisdiction in any state of the United States;

(B) comply with all requirements necessary to give the court jurisdiction; and

(C) abide by the final decision of the court or of any appellate court in the event of an appeal; and

(ii) to designate the commissioner or a designated attorney as its attorney upon whom may be served any lawful process in any action, suit, or proceeding instituted by or on behalf of the ceding company.

(b) Subsection (7)(a)(i) is not intended to conflict with or override the obligation of the parties to a reinsurance agreement to arbitrate their disputes if an obligation is created in the agreement."

Section 29. Section 33-2-1217, MCA, is amended to read:

"33-2-1217. Reduction of liability for reinsurance ceded by domestic insurer to assuming insurer -- definition. A reduction from liability for the reinsurance ceded by a domestic insurer to an assuming insurer not meeting the requirements of 33-2-1216 must be allowed in an amount not exceeding the liabilities carried by the ceding insurer. The reduction must be in the amount of funds held by or on behalf of the ceding insurer, including funds held in trust for the ceding insurer:

(1) under a reinsurance contract with the assuming insurer as security for the payment of

obligations under the contract if the security is held in the United States subject to withdrawal solely by and under the exclusive control of the ceding insurer; or

(2) in the case of a trust, in a qualified United States financial institution. This security may be in the form of:

(a) cash;

(b) securities listed by the securities valuation office of the NAIC and qualifying as admitted assets;

(c) clean, irrevocable, unconditional letters of credit that are issued or confirmed by a qualified United States financial institution no later than December 31 of the year for which filing is being made and that are in the possession of the ceding company on or before the filing date of its annual statement. Letters of credit meeting applicable standards of issuer acceptability as of the dates of their issuance or confirmation must, notwithstanding the issuing or confirming institution's subsequent failure to meet applicable standards of issuer acceptability, continue to be acceptable as security until their expiration, extension, renewal, modification, or amendment, whichever occurs first.

(d) any other form of security acceptable to the commissioner.

(3) For the purposes of subsection (2)(c), a "qualified United States financial institution" means an institution that:

(a) is organized or, in the case of a United States office of a foreign banking organization, licensed under the laws of the United States or any of its states;

(b) is regulated, supervised, and examined by United States federal or state authorities with regulatory authority over banks and trust companies; and

(c) has been determined by either the commissioner or the securities valuation office of the national association of insurance commissioners to meet the standards of financial condition and standing that are considered necessary and appropriate to regulate the quality of financial institutions whose letters of credit will be acceptable to the commissioner.

(4) For the purposes of this part, except for subsection (2)(c), "qualified United States financial institution" means, with respect to institutions eligible to act as a fiduciary of a trust, an institution that:

(a) is organized or, in the case of a United States branch or agency office of a foreign banking corporation, licensed under the laws of the United States or any of its states and that has been granted authority to operate with fiduciary powers; and

(b) is regulated, supervised, and examined by federal or state authorities having regulatory authority

1 over banks and trust companies.

2 (5) The commissioner may adopt rules implementing the provisions of 33-2-307, 33-2-708, and
3 33-2-806."

4
5 **Section 30.** Section 33-2-1218, MCA, is amended to read:

6 **"33-2-1218. Reinsurance agreements affected.** Sections 33-2-1216 and 33-2-1217 apply to all
7 cessions after October 1, 1993, under reinsurance agreements that have had an inception, anniversary, or
8 renewal date on or ~~before~~ after April 1, 1993."

9
10 **SECTION 31. SECTION 33-2-1394, MCA, IS AMENDED TO READ:**

11 **"33-2-1394. Settlement of actions against rehabilitator, liquidator, and employees -- court approval**
12 **-- applicability.** (1) If any legal action against an employee for which indemnity may be available under this
13 section is settled prior to final adjudication on the merits, the insurer shall pay the settlement amount on
14 behalf of the employee or indemnify the employee for the settlement amount unless the commissioner
15 determines:

16 (a) that the claim did not arise out of or by reason of the employee's duties or employment; or

17 (b) that the claim was caused by the intentional or willful and wanton misconduct of the employee.

18 (2) In a legal action in which the rehabilitator or liquidator is a defendant, that portion of any
19 settlement relating to the alleged act, error, or omission of the rehabilitator or liquidator is subject to the
20 approval of the court before which the delinquency proceeding is pending. The court may not approve that
21 portion of the settlement if it determines:

22 (a) that the claim did not arise out of or by reason of the rehabilitator's or liquidator's duties or
23 employment; or

24 (b) that the claim was caused by the intentional or willful and wanton misconduct of the
25 rehabilitator or liquidator.

26 (3) This section may not be construed to deprive the rehabilitator, liquidator, or employee of
27 immunity, indemnity, benefit of law, right, or defense available under any provision of law, including,
28 without limitation, the provisions of Title 2, chapter 9.

29 (4) (a) A Except as otherwise provided, a legal action by a third party does not lie against the
30 rehabilitator, liquidator, or employee based in whole or in part on any alleged act, error, or omission that

1 took place prior to October 1, 1993, unless suit is filed and valid service of process is obtained by October
2 1, 1994. A legal action that is pending on or filed after September 30, 1993, by a liquidator or a liquidation
3 estate will lie against a former special deputy liquidator or any employee, agent, or independent contractor
4 retained by a special deputy liquidator without regard to when the alleged act, error, or omission occurred.

5 (b) Subsections (1) through (3) apply to any suit that is pending on or filed after October 1, 1993,
6 without regard to when the alleged act, error, or omission took place."

7
8 **Section 32.** Section 33-2-1510, MCA, is amended to read:

9 **"33-2-1510. Minimum standards.** Unless there is a written contract between a controlling producer
10 and a controlled insurer specifying the responsibilities of each party, the controlled insurer may not accept
11 business from the controlling producer and the controlling producer may not place business with the
12 controlled insurer. The contract must be approved by the board of directors of the controlled insurer and
13 must contain the following minimum provisions:

14 (1) The controlled insurer may terminate the contract for cause, upon written notice to the
15 controlling producer. The controlled insurer shall suspend the authority of the controlling producer to write
16 business during the pendency of any dispute regarding the cause for the termination.

17 (2) The controlling producer shall render to the controlled insurer accounts detailing all material
18 transactions, including information necessary to support all commissions, charges, and other fees received
19 by or owing to the controlling producer.

20 (3) On at least a monthly basis, the controlling producer shall remit to the controlled insurer all
21 funds due under the terms of the contract. The due date must be fixed so that premiums or installments
22 of premiums collected must be remitted no later than 90 days after the effective date of any policy placed
23 with the controlled insurer under the contract.

24 (4) In accordance with the provisions of this title, all funds collected for the controlled insurer's
25 account must be held by the controlling producer in a fiduciary capacity, in one or more appropriately
26 identified bank accounts in banks that are members of the federal reserve system. However, funds of a
27 controlling producer not required to be licensed in this state must be maintained in compliance with the
28 requirements of the jurisdiction in which the controlling producer's domiciliary jurisdiction producer is
29 domiciled.

30 (5) The controlling producer shall maintain separately identifiable records of business written for

1 the controlled insurer.

2 (6) The contract may not be assigned in whole or in part by the controlling producer.

3 (7) The controlled insurer shall provide the controlling producer with its underwriting standards,
4 rules, procedures, manuals setting forth the rates to be charged, and the conditions for the acceptance or
5 rejection of risks. The controlling producer shall adhere to the standards, rules, procedures, rates, and
6 conditions. The standards, rules, procedures, rates, and conditions must be the same as those applicable
7 to comparable business placed with the controlled insurer by a producer other than the controlling producer.

8 (8) The rates and terms of the controlling producer's commissions, charges, or other fees and the
9 purposes of those commissions, charges, or fees must be contained in the contract. The rates of the
10 controlling producer's commissions, charges, and other fees may not be greater than those applicable to
11 comparable business placed with the controlled insurer by producers other than controlling producers. For
12 purposes of subsection (7) and this subsection, examples of "comparable business" include the same lines
13 of insurance, same kinds of insurance, same kinds of risks, similar policy limits, and similar quality of
14 business.

15 (9) If the contract provides that on insurance business placed with the controlled insurer, the
16 controlling producer is to be compensated contingent upon the controlled insurer's profits on that business,
17 then the compensation may not be determined and paid until at least 5 years after the premiums on liability
18 insurance are earned and at least 1 year after the premiums are earned on any other insurance. The
19 commissions may not be paid until the adequacy of the controlled insurer's reserves on remaining claims
20 has been independently verified pursuant to 33-2-1512.

21 (10) ~~The rates and terms of the controlling producer's commissions, charges, or other fees and~~
22 ~~the purposes of those commissions, charges, or fees~~ A LIMIT ON THE CONTROLLING PRODUCER'S
23 WRITINGS IN RELATION TO THE CONTROLLED INSURER'S SURPLUS AND TOTAL WRITINGS must be
24 contained in the contract. The controlled insurer may establish a different limit for each line or subline of
25 business. The controlled insurer shall notify the controlling producer when the applicable limit is approached
26 and may not accept business from the controlling producer if the limit is reached. The controlling producer
27 may not place business with the controlled insurer if it has been notified by the controlled insurer that the
28 limit has been reached.

29 (11) The controlling producer may negotiate but may not bind reinsurance on behalf of the
30 controlled insurer on business that the controlling producer places with the controlled insurer, except that

1 the controlling producer may bind facultative reinsurance contracts pursuant to obligatory facultative
2 agreements if the contract with the controlled insurer contains underwriting guidelines. For reinsurance
3 assumed and ceded, the guidelines must include a list of reinsurers with which the automatic agreements
4 are in effect, the coverages and amounts or percentages that may be reinsured, and commission
5 schedules."

6
7 **Section 33.** Section 33-2-1605, MCA, is amended to read:

8 **"33-2-1605. Penalties and liabilities.** (1) If, after a hearing conducted in accordance with Title 33,
9 chapter 1, part 7, the commissioner finds that a person has violated any provision of this part, the
10 commissioner may order:

11 (a) a penalty in an amount of \$5,000 for each separate violation;

12 (b) revocation or suspension of the producer's license; and

13 (c) the managing general agent to reimburse the insurer, the rehabilitator, or a liquidator of the
14 insurer for any losses incurred by the insurer caused by a violation of this part committed by the managing
15 general agent.

16 (2) An order of the commissioner pursuant to subsection (1) is subject to judicial review pursuant
17 to 33-1-711.

18 (3) This section does not limit the power of the commissioner to impose any other penalty provided
19 in this title.

20 (4) This part does not limit the rights of policyholders, claimants, or ~~auditors~~ creditors."

21
22 **Section 34.** Section 33-3-431, MCA, is amended to read:

23 **"33-3-431. Borrowed surplus.** (1) A domestic stock or mutual insurer may borrow money to
24 defray the expenses of its organization, to provide it with surplus funds, or for any purpose of its business,
25 upon a written agreement that ~~such the~~ the money is required to be repaid only out of the insurer's surplus in
26 excess of that stipulated in ~~such the~~ the agreement. The agreement may provide for interest at a rate ~~no not~~
27 greater than the rate established in 25-9-205, ~~which interest shall or shall not constitute a liability of the~~
28 ~~insurer as to its funds other than such excess of surplus, as~~ and whether the interest constitutes a liability
29 of the insurer must be stipulated in the agreement. No A commission or promotion expense ~~shall~~ may not
30 be paid in connection with ~~any such a~~ a loan of the type described in this section.

(2) Money ~~so~~ borrowed, together with the interest ~~thereon~~ if ~~so~~ stipulated in the agreement, ~~shall~~ does not form a part of the insurer's legal liabilities except as to its surplus in excess of the amount ~~thereof~~ stipulated in the agreement or ~~be~~ the basis of any setoff; ~~but~~ However, until the money or interest, or both, are repaid, financial statements filed or published by the insurer ~~shall~~ must show as a footnote ~~thereto~~ the amount ~~thereof~~ then unpaid together with any interest ~~thereon~~ accrued but unpaid.

(3) ~~Any such~~ A loan of this type to a mutual or stock insurer ~~shall be~~ is subject to the commissioner's approval. The insurer shall, in advance of the loan, file with the commissioner a statement of the purpose of the loan and a copy of the proposed loan agreement. The loan and agreement ~~shall be deemed~~ are approved unless within 15 days after ~~date of such~~ filing the insurer is notified of the commissioner's disapproval and ~~the reasons therefor~~ reasons for the disapproval. The commissioner shall disapprove any proposed loan or agreement if ~~he~~ the commissioner finds the loan is unnecessary or excessive for the purpose intended or that the terms of the loan agreement are not fair and equitable to the parties, and to other similar lenders, if any, to the insurer, or that the information ~~so~~ filed by the insurer is inadequate.

(4) ~~Any such~~ A loan to a mutual or stock insurer or a substantial portion thereof of the loan ~~shall~~ must be repaid by the insurer when it is no longer reasonably necessary for the purpose originally intended. ~~No repayment of such loan shall~~ Repayment of either principal or interest on the loan may not be made by a mutual or stock insurer unless ~~in advance~~ approved in advance by the commissioner.

(5) This section ~~shall~~ does not apply to loans obtained by the insurer in the ordinary course of business from banks and other financial institutions or to loans secured by pledge or mortgage of assets."

Section 35. Section 33-4-202, MCA, is amended to read:

"33-4-202. Declaration of intention to incorporate -- articles of incorporation -- fee. (1) The individuals proposing to form a farm mutual insurer as referred to in 33-4-201 shall file with the commissioner:

(a) a declaration of their intention to form ~~such a~~ the corporation, ~~which declaration shall be signed~~ by at least 100 incorporators if a proposed state mutual insurer or by at least 25 incorporators if a proposed county mutual insurer; and

(b) proposed articles of incorporation executed in ~~quadruplicate~~ triplicate by three or more of the incorporators and acknowledged by each before a person authorized to take and verify acknowledgments

1 of conveyance of real property.

2 (2) The articles of incorporation ~~shall~~ must state:

3 (a) the name of the corporation. If a state mutual insurer, the words "farm mutual" must be a part
4 of the name; if a county mutual insurer, the name ~~shall~~ must contain the words "farm mutual" or "rural
5 mutual" together with the name of the county ~~wherein is to be located~~ in which its principal place of
6 business is to be located. The name ~~shall~~ may not be so similar to one already used by a corporation in
7 this state as to be misleading.

8 (b) if a county mutual insurer, the name of the county or counties in which the corporation is to
9 transact insurance and the address where its principal business office will be located;

10 (c) if a state mutual insurer, the location of its principal business office, which ~~office~~ must be
11 located in this state;

12 (d) the objects and purposes for which the corporation is formed;

13 (e) whether it intends to transact business on the cash premium plan or the assessment plan;

14 (f) the duration of its existence, which may be perpetual;

15 (g) the number of its directors, which ~~shall~~ may not be less than 5 or more than 11; ~~also, and~~ the
16 names and addresses of the members of the initial board of directors appointed to manage the affairs of
17 the corporation until the first annual meeting of the members and ~~until their~~ successors are elected and
18 qualified;

19 (h) ~~such~~ other provisions, not inconsistent with law, ~~deemed~~ considered appropriate by the
20 incorporators;

21 (i) the names, residences, and addresses of the incorporators and the value of ~~the~~ their property
22 ~~desired to be insured owned by each~~ in the county or counties where the operations of the corporation are
23 to be carried on.

24 (3) At the time of filing of the articles of incorporation as provided in subsection (1) ~~above~~, the
25 incorporators shall pay to the commissioner a filing fee of \$10. The commissioner shall deposit ~~all such~~ the
26 fees with the state treasurer to the credit of the general fund ~~of this state~~.

27
28 **Section 36.** Section 33-4-203, MCA, is amended to read:

29 **"33-4-203. Approval of articles -- commencement of corporate existence.** (1) ~~Upon receipt of~~
30 ~~proposed articles of incorporation, the commissioner shall forward the proposed articles of incorporation~~

1 ~~to the attorney general for examination.~~ If the ~~attorney general~~ commissioner finds the proposed articles
2 of incorporation to be in accordance with the provisions of this chapter and not in conflict with the
3 constitution and laws of the United States of America or of this state, the ~~attorney general~~ commissioner
4 shall make a certificate of the facts ~~and return it with the proposed articles to the commissioner.~~

5 (2) If the commissioner considers the name of the proposed corporation to be so similar to one
6 already appropriated by another company or corporation as to be likely to mislead the public, the
7 commissioner shall reject the name applied for and shall notify the incorporators of the rejection.

8 (3) When the proposed articles of incorporation have been approved by the ~~attorney general~~
9 commissioner, the commissioner shall ~~likewise~~ endorse the commissioner's approval upon each set of the
10 articles and forward ~~four~~ three sets of articles to the incorporators. The incorporators shall file one of the
11 sets of articles with the secretary of state, one set with the commissioner bearing the certification of the
12 secretary of state, and one set with the county clerk of the county in which the principal place of business
13 of the corporation is located and shall pay to the secretary of state and the county clerk the customary
14 filing fees. The remaining set of articles must be made a part of the corporation's records.

15 (4) The corporation has legal existence upon the approval of the articles by the ~~attorney general~~
16 ~~and the commissioner~~ and completion of the filings referred to in subsection (3), but it may not transact
17 business as an insurer until it has fulfilled the requirements for and has obtained a certificate of authority
18 as provided in 33-4-505."

19
20 **Section 37.** Section 33-5-401, MCA, is amended to read:

21 "**33-5-401. Surplus funds required.** (1) A domestic reciprocal insurer ~~hereunder formed~~ subject
22 to this part, if it has otherwise complied with the applicable provisions of this code, may be authorized to
23 transact insurance if it has and ~~thereafter~~ maintains surplus funds as follows:

24 (a) to transact property insurance, surplus funds of not less than \$400,000;

25 (b) to transact casualty insurance; ~~other than workers' compensation, surplus funds of not less~~
26 ~~than \$400,000.~~

27 (i) including authority for workers' compensation insurance, surplus funds of not less than
28 \$600,000; or

29 (ii) excluding authority for workers' compensation insurance, surplus funds of not less than
30 \$400,000.

(2) In addition to surplus funds required to be maintained under subsection (1) ~~above~~, the insurer ~~shall~~ must have, when first ~~so~~ authorized, expendable surplus in the same amount as required of a like foreign reciprocal insurer under 33-2-110.

(3) A domestic reciprocal insurer may be authorized to transact additional kinds of insurance if it has otherwise complied with the provisions of this code ~~therefor~~ for the additional kinds of insurance and ~~possesses and so~~ maintains surplus funds in an amount equal to the minimum capital stock required of a stock insurer for authority to transact a like combination of kinds of insurance."

Section 38. Section 33-7-117, MCA, is amended to read:

"33-7-117. Scope -- provisions applicable. (1) Except as provided in subsection (2), societies are governed by this chapter and are exempt from all other provisions of the insurance laws of this state, not only in governmental relations with the state but for every other purpose. The provisions of a law enacted after January 1, 1992, do not apply to fraternal benefit societies unless expressly made applicable by the provisions of the law.

(2) In addition to the provisions of this chapter, the provisions of chapter 1, parts 1 through 4 and 7; 33-2-104; 33-2-107; 33-2-112; chapter 2, part 13; 33-3-308; 33-15-502; ~~and~~ chapters 17, 18, 20, and 22; and [sections 78 through 81] apply to fraternal benefit societies to the extent applicable and to the extent not in conflict with the provisions of this chapter and the reasonable implications of this chapter."

Section 39. Section 33-10-201, MCA, is amended to read:

"33-10-201. Short title, purpose, scope, and construction. (1) This part ~~shall be known and~~ may be cited as the "Montana Life and Health Insurance Guaranty Association Act".

(2) The purpose of this part is to protect policyowners, insureds, beneficiaries, annuitants, payees, and assignees of life insurance policies, health insurance policies, annuity contracts, and supplemental contracts, subject to certain limitations, against failure in the performance of contractual obligations due to the impairment of the insurer issuing the policies or contracts.

(3) To provide this protection:

(a) an association of insurers is created to enable the guaranty of payment of benefits and of continuation of coverages;

(b) members of the association are subject to assessment to provide funds to carry out the purpose

1 of this part; and

2 (c) the association is authorized to assist the commissioner, in the prescribed manner, in the
3 detection and prevention of insurer impairments.

4 (4) This part applies to direct, nongroup life, health, annuity, and supplemental policies or
5 contracts, to certificates under direct group policies and contracts, and to unallocated annuity contracts
6 issued by member insurers, except as limited by this part. Annuity contracts and certificates under group
7 annuity contracts include but are not limited to guaranteed investment contracts, deposit administration
8 contracts, unallocated funding agreements, allocated funding agreements, structured settlement
9 agreements, lottery contracts, and any immediate or deferred annuity contracts.

10 (5) This part provides coverage for ~~covered~~ policies and contracts specified in subsection (6):

11 (a) to persons who are owners of or certificate holders under covered policies or, in the case of
12 unallocated annuity contracts, to the persons who are contract holders and who if the persons:

13 (i) are residents; or

14 (ii) are not residents, but only under all of the following conditions:

15 (A) the insurers that issued the policies are domiciled in this state;

16 (B) the insurers have not held a license or certificate of authority in the state in which the persons
17 reside;

18 (C) the state has an association similar to the association created under this part; and

19 (D) the persons are not eligible for coverage by that association; and

20 (b) to persons who, regardless of where they reside, except for nonresident certificate holders
21 under group policies or contracts, are the beneficiaries, assignees, or payees of the persons covered under
22 subsection (5)(a).

23 (6) This part covers persons specified in subsection (5)(a) for direct, nongroup life, health, annuity,
24 and supplemental policies and contracts, for certificates under direct group policies and contracts, and for
25 unallocated annuity contracts issued by member insurers, except as limited by this part. Annuity contracts
26 and certificates under group annuity contracts include but are not limited to guaranteed investment
27 contracts, deposit administration contracts, allocated and unallocated funding agreements, structured
28 settlement agreements, lottery contracts, and immediate or deferred annuity contracts. This part does not
29 apply to:

30 (a) ~~any~~ policies or contracts or any part of the policies or contracts under which the risk is borne

1 by the policyholder;

2 (b) ~~any~~ a policy or contract or part of the policy or contract assumed by the impaired insurer under
3 a contract of reinsurance, other than reinsurance for which assumption certificates have been issued;

4 (c) any portion of a policy or contract to the extent that the rate of interest on which it is based:

5 (i) averaged over the period of 4 years prior to the date on which the association becomes
6 obligated with respect to the policy or contract, exceeds a rate of interest determined by subtracting 2
7 percentage points from Moody's corporate bond yield average averaged for that same 4-year period or for
8 the lesser period if the policy or contract was issued less than 4 years before the association became
9 obligated; and

10 (ii) on and after the date on which the association becomes obligated with respect to the policy or
11 contract, exceeds the rate of interest determined by subtracting 3 percentage points from Moody's
12 corporate bond yield average as is most recently available;

13 (d) any plan or program of an employer, association, or similar entity to provide life, health, or
14 annuity benefits to its employees or members to the extent that the plan or program is self-funded or
15 uninsured, including but not limited to benefits payable by an employer, association, or similar entity under:

16 (i) a multiple employer welfare arrangement, as defined in section 514 of the Employee Retirement
17 Income Security Act of 1974, as amended;

18 (ii) a minimum premium group insurance plan;

19 (iii) a stop-loss group insurance plan; or

20 (iv) an administrative services only contract;

21 (e) any portion of a policy or contract to the extent that it provides dividends or experience rating
22 credits or provides that any fees or allowances be paid to any person, including the policy or contract
23 holder, in connection with the service to or administration of the policy or contract;

24 (f) any policy or contract issued in this state by a member insurer at a time when it was not
25 licensed or did not have a certificate of authority to issue the policy or contract in this state;

26 (g) any unallocated annuity contract issued to an employee benefit plan that is protected under the
27 federal pension benefit guaranty corporation; and

28 (h) any portion of any unallocated annuity contract that is not issued to or in connection with a
29 specific employee, union, or association of natural persons benefit plan or a government lottery.

30 (7) This part must be liberally construed to effect the purpose under subsections (2) and (3), which

1 constitute an aid and guide to interpretation.

2 (8) This part may not be construed to reduce the liability for unpaid assessments of the insureds
3 of an impaired insurer operating under a plan with assessment liability."

4

5 **Section 40.** Section 33-10-202, MCA, is amended to read:

6 **"33-10-202. Definitions.** As used in this part, the following definitions apply:

7 (1) "Account" means any of the three accounts created under 33-10-203.

8 (2) "Association" means the Montana life and health insurance guaranty association created under
9 33-10-203.

10 (3) "Contractual obligation" means any obligation under covered policies.

11 (4) "Covered policy" means any policy or contract within the scope of this part under subsections
12 (4) through (6) of 33-10-201.

13 (5) "Impaired insurer" means:

14 (a) an insurer which after July 1, 1974, becomes insolvent and is placed under a final order of
15 liquidation, rehabilitation, or supervision by a court of competent jurisdiction; or

16 (b) an insurer considered by the commissioner after July 1, 1974, to be unable or potentially unable
17 to fulfill its contractual obligations.

18 (6) (a) "Member insurer" means any person authorized to transact in this state any kind of
19 insurance to which this part applies under subsections (4) and (6) of 33-10-201 insurer that is licensed or
20 that holds a certificate of authority to transact any kind of insurance in this state for which coverage is
21 provided under 33-2-201 and includes any insurer whose license or certificate of authority may have been
22 suspended, revoked, not renewed, or voluntarily withdrawn.

23 (b) The term does not include:

24 (i) a health service corporation;

25 (ii) a health maintenance organization;

26 (iii) a fraternal benefit society;

27 (iv) a mandatory state pooling plan;

28 (v) a mutual assessment company or any entity that operates on an assessment basis;

29 (vi) an insurance exchange; or

30 (vii) an entity similar to any of the entities listed in subsections (6)(b)(i) through (6)(b)(vi).

(7) "Person" means any individual, corporation, partnership, association, or voluntary organization.

(8) "Premiums" means direct gross insurance premiums and annuity considerations written on covered policies, less return premiums and considerations on premiums and dividends paid or credited to policyholders on the direct business. "Premiums" do not include premiums and considerations on contracts between insurers and reinsurers. As used in 33-10-227, "premiums" are those for the calendar year preceding the determination of impairment.

(9) "Resident" means any person who resides in this state at the time the impairment is determined and to whom contractual obligations are owed.

(10) "Unallocated annuity contract" means an annuity contract or group annuity certificate that is not issued to and owned by an individual, except to the extent of annuity benefits guaranteed to an individual by the insurer under the contract or certificate."

Section 41. Section 33-11-102, MCA, is amended to read:

"33-11-102. Definitions. As used in this part, the following definitions apply:

(1) "Completed operations liability" means:

(a) liability arising out of the installation, maintenance, or repair of any product at a site that is not owned or controlled by:

(i) a person who performs that work; or

(ii) a person who hires an independent contractor to perform that work; and

(b) liability for activities that are completed or abandoned before the date of the occurrence giving rise to the liability.

(2) "Domicile", for purposes of determining the state where a purchasing group is domiciled, means:

(a) for a corporation, the state where the purchasing group is incorporated; and

(b) for an unincorporated entity, the state of its principal place of business.

~~(2)~~(3) "Hazardous financial condition" means that, based on its present or reasonably anticipated financial condition, a risk retention group, although not yet financially impaired or insolvent, is unlikely to be able to:

(a) meet obligations to policyholders with respect to known claims and reasonably anticipated claims; or

1 (b) pay other obligations in the normal course of business.

2 ~~(3)~~(4) "Insurance" means primary insurance, excess insurance, reinsurance, surplus line insurance,
3 and any other arrangement for shifting and distributing risk that is determined to be insurance under the
4 laws of this state.

5 ~~(4)~~(5) (a) "Liability" means legal liability for damages, including costs of defense, legal costs and
6 fees, and other claims expenses, because of injuries to other persons, damage to their property, or other
7 damage or loss to other persons resulting from or arising out of:

8 (i) a business, whether profit or nonprofit, trade, product, service (including professional service),
9 premises, or operation; or

10 (ii) an activity of any state or local government or an agency or political subdivision ~~thereof~~ of state
11 or local government.

12 (b) The term does not include personal risk liability or an employer's liability with respect to its
13 employees other than legal liability under the federal Employers' Liability Act, ~~{45 U.S.C. 51 through 60}~~.
14 As used in this subsection, "personal risk liability" means liability for damages because of injury to any
15 person, damage to property, or other loss or damage resulting from personal, familial, or household
16 responsibilities or activities rather than from responsibilities or activities referred to in subsection ~~(4)~~(a)
17 ~~(5)~~(a).

18 ~~(5)~~(6) "Plan of operation or a feasibility study" means an analysis that presents the expected
19 activities and results of a risk retention group, including at a minimum:

20 (a) the coverages, deductibles, coverage limits, rates, and rating classification systems for each
21 line of insurance the group intends to offer;

22 (b) historical and expected loss experience of the proposed members and national experience of
23 similar exposures to the extent this experience is reasonably available;

24 (c) pro forma financial statements and projections;

25 (d) appropriate opinions by a qualified independent casualty actuary, including a determination of
26 minimum premium or participation levels required to commence operations and to prevent a hazardous
27 financial condition;

28 (e) identification of management, underwriting procedures, managerial oversight methods, and
29 investment policies; and

30 (f) other matters as may be prescribed by the commissioner for liability insurance companies

1 authorized by the insurance laws of the state where the risk retention group is chartered.

2 ~~(6)~~(7) "Purchasing group" means a group that:

3 (a) has as one of its purposes the purchase of liability insurance on a group basis;

4 (b) purchases liability insurance only for its group members and only to cover their similar or related
5 liability exposure, as described in subsection ~~(6)(c)~~ (7)(c);

6 (c) is composed of members whose businesses or activities are similar or related with respect to
7 the liability to which members are exposed by virtue of any related, similar, or common business, trade,
8 product, service, premises, or operation; and

9 (d) is domiciled in any state.

10 ~~(7)~~(8) "Risk retention group" means a corporation or other limited liability association formed under
11 the laws of any state, Bermuda, or the Cayman Islands:

12 (a) whose primary activity consists of assuming and spreading all or any portion of the liability
13 exposure of its group members;

14 (b) that is organized for the primary purpose of conducting the activity described under subsection
15 ~~(7)(a)~~ (8)(a);

16 (c) (i) that is chartered and licensed as a liability insurance company and authorized to engage in
17 the business of insurance under the laws of any state; or

18 (ii) that, before January 1, 1985, was chartered or licensed and authorized to engage in the
19 business of insurance under the laws of Bermuda or the Cayman Islands and, before that date, had certified
20 to the insurance regulatory official of at least one state that it satisfied the capitalization requirements of
21 that state. However, ~~such~~ the group is considered to be a risk retention group only if it has been engaged
22 in business continuously since January 1, 1985, and only for the purpose of continuing to provide
23 insurance to cover product liability or completed operations liability.

24 ~~(A) For purposes of this subsection (7), "completed operations liability" means liability arising out~~
25 ~~of the installation, maintenance, or repair of any product at a site which is not owned or controlled by a~~
26 ~~person who performs that work or hires an independent contractor to perform that work and includes~~
27 ~~liability for activities which are completed or abandoned before the date of the occurrence giving rise to the~~
28 ~~liability.~~

29 ~~(B)~~ For purposes of this subsection ~~(7)~~ (8), "product liability" means liability for damages because
30 of any personal injury, death, emotional harm, consequential economic damage, or property damage,

1 ~~{including damages resulting from the loss of use of property}~~, arising out of the manufacture, design,
 2 importation, distribution, packaging, labeling, lease, or sale of a product but does not include the liability
 3 of any person for those damages if the product involved was in the possession of that person when the
 4 incident giving rise to the claim occurred.

5 (d) that does not exclude any person from membership in the group solely to provide to members
 6 of the group a competitive advantage over ~~such~~ the person;

7 (e) (i) that has as its members only persons who have an ownership interest in the group and that
 8 has as its owners only persons who are members and who are provided insurance by the risk retention
 9 group; or

10 (ii) that has as its sole member and sole owner an organization that is owned by persons who are
 11 provided insurance by the risk retention group;

12 (f) whose members are engaged in businesses or activities that are similar or related with respect
 13 to the liability to which the members are exposed by virtue of any related, similar, or common business,
 14 trade, product, service, premises, or operation;

15 (g) whose activities do not include the provision of insurance other than:

16 (i) liability insurance for assuming and spreading all or any portion of the liability of its group
 17 members; and

18 (ii) reinsurance with respect to the liability of any other risk retention group or member of ~~such~~ the
 19 other group that is engaged in businesses or activities so that ~~such~~ the group or member meets the
 20 requirement described in subsection ~~(7)(f)~~ (8)(f) for membership in the risk retention group that provides
 21 the reinsurance; and

22 (h) whose name includes the phrase "risk retention group".

23 ~~(8)(9)~~ "State" means any state of the United States or the District of Columbia."
 24

25 **Section 42.** Section 33-11-104, MCA, is amended to read:

26 **"33-11-104. Risk retention groups not chartered in this state.** A risk retention group chartered in
 27 a state other than this state and seeking to do business as a risk retention group in this state must observe
 28 and abide by the laws of this state as follows:

29 (1) Before offering insurance in this state, a risk retention group shall submit to the commissioner:

30 (a) a statement identifying the state or states where the risk retention group is chartered and

1 authorized as a casualty insurer, date of chartering, its principal place of business, and other information,
2 including information on its membership, as the commissioner requires to verify that the risk retention group
3 is qualified under 33-11-102~~(7)~~(8);

4 (b) a copy of its plan of operation or a feasibility study and revisions of the plan or study submitted
5 to its state of domicile. However, this provision relating to the submission of a plan of operation or a
6 feasibility study does not apply with respect to any line or classification of liability insurance that was
7 defined in the federal Product Liability Risk Retention Act of 1981 (15 U.S.C. 3901 through 3904) before
8 it was amended by P.L. 99-563, approved on October 27, 1986, and that was offered before that date by
9 a risk retention group that had been chartered and operated for not less than 3 years before that date; and

10 (c) a statement of registration that designates the commissioner as its agent for the purpose of
11 receiving service of legal documents or process.

12 (2) A risk retention group doing business in this state shall submit to the commissioner:

13 (a) a copy of the group's financial statement submitted to its state of domicile, which must be
14 certified by an independent public accountant and contain a statement of opinion on loss and loss
15 adjustment expense reserves made by a member of the American academy of actuaries or by a qualified
16 loss reserve specialist under criteria established by the national association of insurance commissioners;

17 (b) a copy of each examination of the risk retention group as certified by the insurance regulatory
18 official of the state in which the examination was conducted or public official conducting the examination;

19 (c) upon request by the commissioner, a copy of any audit performed with respect to the risk
20 retention group; and

21 (d) any information as may be required to verify the group's continuing qualification as a risk
22 retention group under 33-11-102~~(7)~~(8).

23 (3) (a) Each risk retention group is liable for the payment of premium taxes and taxes on premiums
24 of direct business for risks resident or located within this state and shall report to the commissioner the net
25 premiums written for risks resident or located within this state. The risk retention group is subject to
26 taxation and any applicable interest, fines, and penalties for nonpayment that apply to foreign admitted
27 insurers.

28 (b) To the extent that an insurance producer is used, the insurance producer shall report to the
29 commissioner the premiums of direct business for risks resident or located within this state that the
30 licensees have placed with or on behalf of a risk retention group not chartered in this state.

1 (c) To the extent that an insurance producer is used, the insurance producer shall keep a complete
2 and separate record of all policies procured from each risk retention group. The record is open to
3 examination by the commissioner, as provided in 33-1-408. The records must, for each policy and each
4 kind of insurance provided under the policy, include the limit of liability, the time period covered, the
5 effective date, the name of the risk retention group that issued the policy, the gross premium charged, and
6 the amount of return premiums, if any.

7 (4) Each risk retention group, its insurance producers, and its representatives shall comply with
8 Title 33, chapter 18, part 2.

9 (5) Each risk retention group shall comply with the provisions of Title 33, chapter 18, part 2,
10 regarding deceptive, false, or fraudulent acts or practices. However, if the commissioner seeks an injunction
11 regarding the risk retention group's conduct, the injunction must be obtained from a court of competent
12 jurisdiction.

13 (6) Each risk retention group shall submit to an examination by the commissioner to determine its
14 financial condition if the insurance regulatory official of the jurisdiction where the group is chartered has
15 not initiated an examination or does not initiate an examination within 60 days after a request by the
16 commissioner. The examination must be coordinated to avoid unjustified repetition and be conducted in an
17 expeditious manner in accordance with the national association of insurance commissioners examiners
18 handbook.

19 (7) Each policy issued by a risk retention group must contain, in 10-point type on the front page
20 and the declaration page, the following notice:

21 "NOTICE

22 This policy is issued by your risk retention group. Your risk retention group may not be subject to
23 all of the insurance laws and regulations of your state. State insurance insolvency guaranty funds are not
24 available for your risk retention group."

25 (8) The following acts by a risk retention group are prohibited:

26 (a) the solicitation or sale of insurance by a risk retention group to any person who is not eligible
27 for membership in the group; and

28 (b) the solicitation or sale of insurance by or operation of a risk retention group that is in a
29 hazardous financial condition or is financially impaired.

30 (9) A risk retention group is not allowed to do business in this state if an insurer is directly or

indirectly a member or owner of the risk retention group, other than in the case of a risk retention group all of whose members are insurers.

(10) A risk retention group may not offer insurance policy coverage declared unlawful by the Montana supreme court.

(11) A risk retention group not chartered in this state and doing business in this state shall comply with a lawful order issued in a voluntary dissolution proceeding or in a delinquency proceeding commenced by the insurance regulatory official of any state if there has been a finding of financial impairment after an examination under subsection (6).

(12) Upon completion of registration requirements, the commissioner shall issue to the risk retention group a proper certificate of registration.

(13) A risk retention group that violates any provision of this chapter is subject to fines and penalties, including revocation of the right to do business in this state, applicable to licensed insurers generally."

Section 43. Section 33-11-108, MCA, is amended to read:

"33-11-108. Notice and registration requirements of purchasing groups. (1) A purchasing group that intends to do business in this state shall furnish notice to the commissioner that:

(a) identifies the state where the group is domiciled and all other states in which the group intends to do business;

(b) specifies the lines and classifications of liability insurance that the purchasing group intends to purchase;

(c) identifies the insurer from which the purchasing group intends to purchase its insurance and the domicile of ~~the~~ that insurer;

(d) identifies the Montana-licensed insurance producer or Montana-licensed surplus lines insurance producer through which the purchasing group intends to place its business;

(e) identifies the principal place of business of the purchasing group; ~~and~~

(f) provides information required by the commissioner to verify that the purchasing group is qualified under 33-11-102~~(6)~~(7); ~~and~~

(g) identifies the person or persons controlling the activities of the group and includes biographical information on the person or persons.

(2) The purchasing group shall register with and designate the commissioner as its agent solely for the purpose of receiving service of legal documents or process. However, the requirements do not apply in the case of a purchasing group:

- (a) (i) that was domiciled before April 2, 1986, in any state of the United States; and
- (ii) that was domiciled on and after October 27, 1986, in any state of the United States;
- (b) (i) that, before October 27, 1986, purchased insurance from an insurer licensed in any state; and
- (ii) that, since October 27, 1986, purchased its insurance from an insurer licensed in any state;
- (c) that was a purchasing group under the requirements of the federal Product Liability Risk Retention Act of 1981 (15 U.S.C. 3901 through 3904) before it was amended by P.L. 99-563, approved on October 27, 1986; and
- (d) that does not purchase insurance that was not authorized for purposes of an exemption under the federal Product Liability Risk Retention Act of 1981, as in effect before October 27, 1986.

(3) Upon completion of registration requirements, the commissioner shall issue a proper certificate of registration to the purchasing group."

Section 44. Section 33-14-304, MCA, is amended to read:

"33-14-304. Cancellation of insurance upon default. (1) When a premium finance agreement contains a power of attorney or other authority enabling the insurance premium finance company to cancel any insurance contract listed in the agreement, the insurance contract or contracts may not be canceled by the premium finance company unless ~~such~~ the cancellation is effectuated in accordance with this section.

(2) ~~Not less than 10 days' written~~ Written notice must be mailed to the insured setting forth the intent of the insurance premium finance company to cancel the insurance contract unless the default is cured prior to the date stated in the notice. The written notice must be mailed at least 10 days prior to the date stated in the notice. The insurance producer ~~or broker~~ indicated on the premium finance agreement ~~shall~~ must also be mailed 10 days' notice of this action.

(3) Pursuant to the power of attorney or other authority referred to above, the insurance premium finance company may cancel on behalf of the insured by mailing to the insurer written notice stating when ~~thereafter~~ the cancellation ~~shall be~~ will become effective, and the insurance contract ~~shall~~ must be canceled

as if ~~such~~ the notice of cancellation had been submitted by the insured ~~himself~~ but without requiring the return of the insurance contract. If the insurer or its insurance producer does not provide the insurance premium finance company with a specific mailing address for the purpose of receipt of the ~~above~~ notice, mailing by the insurance premium finance company to the insurer at the address that is on file ~~and of record~~ with the commissioner is considered sufficient notice under this section. The insurance premium finance company shall also mail a notice of cancellation to the insured at ~~his~~ the insured's last-known address and to the insurance producer ~~or broker~~ indicated on the premium finance agreement.

(4) All statutory, regulatory, and contractual restrictions providing that the insurance contract may not be canceled unless notice is given to a governmental agency, mortgagee, or other third party apply whenever cancellation is effected under the provisions of this section. The insurer shall give the prescribed notice in behalf of itself or the insured to any governmental agency, mortgagee, or other third party on or before the second business day after the day it receives the notice of cancellation from the premium finance company and shall determine the effective date of cancellation taking into consideration the number of days' notice required to complete the cancellation."

Section 45. Section 33-15-301, MCA, is amended to read:

"33-15-301. Requiring standard provisions -- waiver. (1) Insurance contracts ~~shall~~ must contain ~~such the~~ standard or uniform provisions ~~as are~~ and benefits required by the applicable provisions of this code pertaining to contracts of particular kinds of insurance. The commissioner may waive ~~the required use~~ of a particular provision in a particular insurance policy form if:

(a) ~~he the commissioner~~ finds ~~such the~~ provision or benefit unnecessary for the protection of the insured and inconsistent with the purposes of the policy; and

(b) the policy is otherwise approved by ~~him~~ the commissioner.

(2) ~~No A~~ policy or certificate ~~shall~~ may not contain any provision or benefit inconsistent with or contradictory to any standard or uniform provision or benefit used or required to be used, but the commissioner may approve any substitute provision or benefit ~~which that is, in his~~ the commissioner's opinion, not less favorable in any particular to the insured or beneficiary than the provisions otherwise required.

(3) In lieu of the provisions required by this code for contracts for particular kinds of insurance, substantially similar provisions required by the law of the domicile of a foreign or alien insurer may be used

1 when approved by the commissioner.

2 (4) ~~No such~~ A provision, if required to be contained in the policy, ~~can~~ may not be waived by
3 agreement between the insurer and any other person."

4
5 **Section 46.** Section 33-15-303, MCA, is amended to read:

6 **"33-15-303. Contents of policies in general -- identification.** (1) ~~Every~~ Each policy ~~shall~~ must
7 specify:

8 (a) the names of the parties to the contract;

9 (b) the subject of the insurance;

10 (c) the risks insured against;

11 (d) the time when the insurance under the policy takes effect and the period during which the
12 insurance is to continue;

13 (e) the premium;

14 (f) the conditions pertaining to the insurance.

15 (2) If under the policy the exact amount of premium is determinable only at stated intervals or
16 termination of the contract, a statement of the basis and rates upon which the premium is to be determined
17 and paid must be included.

18 (3) All policies and annuity contracts issued by insurers and the forms of policies and annuity
19 contracts filed with the commissioner must have printed on the policy or annuity contract an appropriate
20 designating letter or figure, combination of letters or figures, or terms identifying the respective forms of
21 policies or contracts, ~~together with the year of adoption of the form.~~ Each form, including riders and
22 endorsements, must be identified by a designating letter or figure placed in a lower, preferably left-hand,
23 corner of the first page of the form. Whenever any change is made in any form, the designating letters,
24 figures, or terms ~~and year of adoption~~ on the form must be correspondingly changed and the revision date
25 must be noted next to the designating letters."

26
27 **Section 47.** Section 33-16-202, MCA, is amended to read:

28 **"33-16-202. Recording and reporting of loss and expense experience.** (1) The commissioner ~~shall~~
29 may promulgate and may modify reasonable rules and statistical plans, reasonably adapted to each of the
30 rating systems used, ~~and which shall~~ must thereafter be used by each insurer in the recording and reporting

1 of its loss and countrywide expense experience, in order that the experience of all insurers may be made
2 available at least annually in ~~such~~ form and detail as ~~may be~~ necessary to aid ~~him~~ the commissioner in
3 determining whether rates comply with the applicable standards of this chapter. ~~Such~~ The rules and plans
4 may also provide for the recording and reporting of expense experience items ~~which~~ that are specially
5 applicable to this state and are not susceptible of determination by a prorating of countrywide expense
6 experience.

7 (2) In promulgating ~~such~~ rules and plans, the commissioner shall give ~~due~~ consideration to the
8 rating systems in use in this state and, in order that ~~such~~ the rules and plans may be as uniform as is
9 practicable among the several states, to the rules and to the form of the plans used for ~~such~~ rating systems
10 in other states. ~~No~~ An insurer ~~shall~~ may not be required to record or report its loss experience on a
11 classification basis that is inconsistent with the rating system used by it.

12 (3) The commissioner may designate one or more rating organizations or other agencies to assist
13 ~~him~~ in gathering ~~such~~ and making compilations of loss and expense experience ~~and making compilations~~
14 ~~thereof~~, and ~~such~~ the compilations ~~shall~~ must be made available, subject to reasonable rules promulgated
15 by the commissioner, to insurers and rating organizations."

16
17 **Section 48.** Section 33-16-235, MCA, is amended to read:

18 **"33-16-235. Data reporting -- rules.** (1) An insurer that has transacted a line of insurance
19 designated as noncompetitive or volatile ~~shall~~ may report once a year to the commissioner, on forms
20 prescribed by the commissioner, information including:

- 21 (a) reported and estimated ultimate exposure, by year of exposure to loss;
- 22 (b) reported and estimated ultimate premiums, by year of exposure to loss;
- 23 (c) losses paid, by year incurred;
- 24 (d) loss adjustment expense paid, by year incurred;
- 25 (e) reported and ultimately incurred losses and loss adjustment expenses, by year incurred; and
- 26 (f) any other information required by the commissioner.

27 (2) An insurer transacting a line of insurance designated as noncompetitive or volatile shall provide
28 to the commissioner information concerning at least 5 years of experience, with information evaluated as
29 of the end of each calendar year. In addition to the latest reported information for each year, the insurer
30 shall document any adjustments, including but not limited to development factors and trend adjustments,

1 made to the reported data in projecting losses.

2 (3) The commissioner ~~shall~~ may adopt by rule reasonable development factors and trend
3 adjustments to be applied to the reported data."

4
5 **Section 49.** Section 33-17-102, MCA, is amended to read:

6 **"33-17-102. Definitions.** As used in this title, the following definitions apply:

7 (1) "Adjuster" means a person who, on behalf of the insurer, for compensation as an independent
8 contractor or as the employee of an independent contractor or for fee or commission investigates and
9 negotiates settlement of claims arising under insurance contracts or otherwise acts on behalf of the insurer.

10 The term does not include a:

11 (a) licensed attorney who is qualified to practice law in this state;

12 (b) salaried employee of an insurer or of a managing general agent; ~~or~~

13 (c) licensed insurance producer who adjusts or assists in adjustment of losses arising under policies
14 issued by the insurer; or

15 (d) licensed third-party administrator who adjusts or assists in adjustment of losses arising under
16 policies issued by the insurer.

17 (2) "Adjuster license" means a document issued by the commissioner that authorizes a person to
18 act as an adjuster.

19 (3) (a) "Administrator" means a person who collects charges or premiums from residents of this
20 state in connection with life, disability, property, or casualty insurance or annuities or who adjusts or settles
21 claims on ~~such coverage~~ these coverages.

22 (b) The term does not mean:

23 (i) an employer on behalf of its employees or on behalf of the employees of one or more
24 subsidiaries of affiliated corporations of the employer;

25 (ii) a union on behalf of its members;

26 (iii) (A) an insurer that is either authorized in this state or acting as an insurer with respect to a
27 policy lawfully issued and delivered by it in and pursuant to the laws of a state in which the insurer is
28 authorized to transact insurance; or

29 (B) a health service corporation as defined in 33-30-101;

30 (iv) a life, disability, property, or casualty insurance producer who is licensed in this state and

1 whose activities are limited exclusively to the sale of insurance;

2 (v) a creditor on behalf of its debtors with respect to insurance covering a debt between the
3 creditor and its debtors;

4 (vi) a trust established in conformity with 29 U.S.C. 186 or the trustees, agents, and employees
5 of the trust;

6 (vii) a trust exempt from taxation under section 501(a) of the Internal Revenue Code or the trustees
7 and employees of the trust;

8 (viii) a custodian acting pursuant to a custodian account that meets the requirements of section
9 401(f) of the Internal Revenue Code or the agents and employees of the custodian;

10 (ix) a bank, credit union, or other financial institution that is subject to supervision or examination
11 by federal or state banking authorities;

12 (x) a company that issues credit cards and that advances for and collects premiums or charges
13 from its credit card holders who have authorized it to do so, if the company does not adjust or settle claims;
14 or

15 (xi) a person who adjusts or settles claims in the normal course of ~~his~~ the person's practice or
16 employment as an attorney and who does not collect charges or premiums in connection with life or
17 disability insurance or annuities.

18 (4) "Administrator license" means a document issued by the commissioner that authorizes a person
19 to act as an administrator.

20 (5) "Consultant" means a person who for a fee examines, appraises, reviews, or evaluates an
21 insurance policy, annuity, or pension contract, plan, or program or who makes recommendations or gives
22 advice on an insurance policy, annuity, or pension contract, plan, or program.

23 (6) "Consultant license" means a document issued by the commissioner that authorizes a person
24 to act as an insurance consultant.

25 (7) "Controlled business" means insurance procured or to be procured by or through a person upon
26 the life, person, property, or risks of ~~himself the person, his or the person's~~ spouse, ~~his~~ employer, or ~~his~~
27 business.

28 (8) "Individual" means a private or natural person, as distinguished from a partnership, corporation,
29 or association.

30 (9) "Insurance producer", except as provided in 33-17-103:

1 (a) means:

2 (i) a person who solicits, negotiates, effects, procures, delivers, renews, continues, or binds:

3 (A) policies of insurance for risks residing, located, or to be performed in this state; or

4 (B) membership contracts as defined in 33-30-101;

5 (ii) a managing general agent. For purposes of this definition, ~~a chapter, the term~~ "managing general
6 agent" ~~is a person who, on behalf of an insurer, exercises general supervision over the business of the~~
7 ~~insurer in this state or in any other state, including the authority to contract with an insurance producer for~~
8 ~~the insurer and terminate those contracts~~ has the same meaning as set forth in 33-2-1501.

9 (b) does not mean a customer service representative. For purposes of this definition, a "customer
10 service representative" means a salaried employee of an insurance producer who assists and is responsible
11 to the insurance producer.

12 (10) "License" means a document issued by the commissioner that authorizes a person to act as
13 an insurance producer for the kinds of insurance specified in the document. The license itself does not
14 create actual, apparent, or inherent authority in the holder to represent or commit an insurer to a binding
15 agreement.

16 (11) "Person" means an individual, partnership, corporation, association, or other legal entity.

17 (12) "Public adjuster" means an adjuster employed by and representing the interests of the insured."
18

19 **Section 50.** Section 33-17-211, MCA, is amended to read:

20 **"33-17-211. General qualifications -- application for license.** (1) An individual applying for a
21 license shall apply on a form specified by the commissioner and declare under penalty of refusal,
22 suspension, or revocation of the license that statements made in the application are true, correct, and
23 complete to the best of the individual's knowledge and belief. Before approving the application, the
24 commissioner shall verify that the individual:

25 (a) is 18 years of age or older;

26 (b) has not committed an act that is a ground for refusal, suspension, or revocation as set forth
27 in 33-17-1001;

28 (c) has paid the license fees stated in 33-2-708;

29 (d) has successfully passed the examinations for each kind of insurance for which the individual
30 has applied within 12 months of application;

(e) is a resident of this state or of another state that grants similar privileges to residents of this state. Licenses issued based upon Montana state residency terminate if the licensee relocates to another state;

(f) is competent, trustworthy, and of good reputation;

(g) has experience or training or otherwise is qualified in the kind or kinds of insurance for which ~~he~~ the applicant applies to be licensed and is reasonably familiar with the provisions of this code which govern ~~his~~ the applicant's operations as an insurance producer; and

(h) if applying for a license as to life or disability insurance:

(i) is not a funeral director, undertaker, or mortician operating in this or any other state;

(ii) is not an officer, employee, or representative of a funeral director, undertaker, or mortician operating in this or any other state; or

(iii) does not hold an interest in or benefit from a business of a funeral director, undertaker, or mortician operating in this or any other state.

(2) A person acting as an insurance producer shall obtain a license. A person shall apply for a license on a form specified by the commissioner. Before approving the application, the commissioner shall verify that:

(a) the person meets the requirements listed in subsection (1);

(b) the person has paid the licensing fees stated in 33-2-708 for each individual licensed in conjunction with the person's license. A licensed person shall promptly notify the commissioner of each change relating to an individual listed in the license.

(c) the person has designated a licensed officer responsible for compliance by the person with the insurance laws and rules of this state;

(d) each member and employee of a partnership and each officer, director, stockholder, or employee of a corporation who is acting as an insurance producer in this state has obtained a license;

(e) (i) if the person is a partnership or corporation, the transaction of insurance business is within the purposes stated in the partnership agreement or the articles of incorporation; and

(ii) if the person is a corporation, the secretary of state has issued a certificate of existence or authorization under 35-1-1312 or filed articles of incorporation under ~~35-2-214~~ 35-1-220.

(3) The commissioner may license as a resident insurance producer an association of licensed Montana insurance producers, whether or not incorporated, formed and existing substantially for purposes

1 other than insurance. The license must be used solely for the purpose of enabling the association to place,
2 as a resident insurance producer, insurance of the properties, interests, and risks of the state of Montana
3 and of other public agencies, bodies, and institutions and to receive the customary commission for the
4 placement. The president and secretary of the association shall apply for the license in the name of the
5 association, and the commissioner shall issue the license to the association in its name alone. The fee for
6 the license is the same as that required by 33-2-708 for the license of an insurance producer. The
7 commissioner may, after a hearing with notice to the association, revoke the license if ~~he~~ the commissioner
8 finds that continuation of the license is not in the public interest or that a ground listed in 33-17-1001
9 exists.

10 (4) An insurance producer using an assumed business name shall register the name with the
11 commissioner before using it."

12
13 **Section 51.** Section 33-17-405, MCA, is amended to read:

14 **"33-17-405. Service of process -- commissioner as agent.** ~~A nonresident person shall file with the~~
15 ~~commissioner the required forms appointing the~~ The commissioner and his successors in office shall act
16 ~~as the a~~ nonresident person's agent upon whom process in a legal proceeding against the nonresident
17 person may be served, ~~and shall agree that such~~ Service of process on the commissioner process has ~~has~~
18 the same legal force and validity as personal service of process upon the nonresident person. The
19 commissioner shall, within 3 working days after receiving process, forward by certified mail, at to the
20 nonresident person's address of record, a copy of the process ~~by certified mail to the person for whom he~~
21 ~~has received the process.~~"

22
23 **Section 52.** Section 33-17-503, MCA, is amended to read:

24 **"33-17-503. Application -- fee -- expiration.** (1) Before a consultant license is issued or renewed,
25 the prospective licensee shall:

26 (a) properly file in the office of the commissioner a written application on forms the commissioner
27 prescribes; and

28 (b) pay a fee of \$50, which the commissioner shall deposit with the state treasurer to be credited
29 to the state's general fund.

30 (2) Each consultant license ~~expires on May 31 next following the date of issue~~ must be renewed

1 each year by the consultant paying a continuation fee on or before May 31, and the license continues in
2 force unless suspended, revoked, or otherwise terminated."

3
4 **Section 53.** Section 33-17-603, MCA, is amended to read:

5 **"33-17-603. Certificate of registration.** (1) Except as provided in 33-17-604, a person may not
6 act as or ~~hold himself out to be~~ represent to the public that the person is an administrator in this state
7 unless ~~he~~ the person holds a certificate of registration as an administrator.

8 (2) An application for a certificate of registration must be accompanied by a fee of \$100. The
9 commissioner shall issue the certificate unless ~~he~~ the commissioner finds that the applicant is not
10 competent, trustworthy, financially responsible, or of good personal and business reputation or that the
11 applicant has had a previous application for a license denied for cause within 5 years.

12 (3) ~~The A certificate of registration is renewable annually on July 1. A request for renewal must~~
13 ~~be accompanied by a renewal fee of \$100~~ must be renewed each year by the administrator paying a
14 continuation fee of \$100 on or before July 1. Upon payment, the license continues in force unless
15 suspended, revoked, or otherwise terminated. The commissioner shall deposit the fee with the state
16 treasurer to be credited to the general fund.

17 (4) ~~The A~~ certificate of registration may be suspended or revoked if, after notice and hearing, the
18 commissioner finds that the administrator has violated any of the requirements of this part or that the
19 administrator is not competent, trustworthy, financially responsible, or of good personal and business
20 reputation.

21 (5) Unless ~~the a~~ certification requirement is waived, a person who acts as an administrator without
22 a certificate of registration is subject to a fine of not less than \$500 or more than \$1,500."

23
24 ~~**Section 53.** Section 33-17-1001, MCA, is amended to read:~~

25 ~~**"33-17-1001. Suspension, revocation, or refusal of license.** (1) Except as provided in 33-17-411,~~
26 ~~after a hearing, which must be held no less than 10 days after advance notice by certified mail, on charges~~
27 ~~given under 33-1-314(3), the commissioner may suspend for up to 5 years, revoke, refuse to continue, or~~
28 ~~deny a license issued under this chapter if the commissioner finds that the licensee or applicant has:~~

29 ~~(a) engaged or is about to engage in an act or practice for which issuance of the license could have~~
30 ~~been refused;~~

1 ~~(b) obtained or attempted to obtain a license through misrepresentation or fraud;~~
2 ~~(c) violated or failed to comply with a provision of this code or has violated a rule, subpoena, or~~
3 ~~order of the commissioner or of the commissioner of any other state;~~
4 ~~(d) improperly withheld, misappropriated, or converted to the licensee's or applicant's own use~~
5 ~~money or property belonging to policyholders, insurers, beneficiaries, or others and received in conduct of~~
6 ~~business under the license;~~
7 ~~(e) been convicted of a felony;~~
8 ~~(f) in the conduct of the affairs under the license, used fraudulent, coercive, or dishonest practices~~
9 ~~or the licensee or applicant is incompetent, untrustworthy, financially irresponsible, or a source of injury~~
10 ~~and loss to the public;~~
11 ~~(g) made a materially untrue statement in the license application or in the continuing education~~
12 ~~affidavit;~~
13 ~~(h) misrepresented the terms of an actual or proposed insurance contract;~~
14 ~~(i) been found guilty of an unfair trade practice or fraud prohibited by Title 33, chapter 18;~~
15 ~~(j) had a similar license suspended or revoked in any other state;~~
16 ~~(k) forged another's name to an application for insurance;~~
17 ~~(l) cheated on an examination for a license; or~~
18 ~~(m) knowingly accepted insurance business from a person who is not licensed.~~
19 ~~(2) The license of a partnership or corporation may be suspended, revoked, refused, or denied if~~
20 ~~a reason listed in subsection (1) applies to an individual designated in the license to exercise its powers or~~
21 ~~to a partner or officer in the partnership or corporation.~~
22 ~~(3) The commissioner may suspend, revoke, or refuse to continue a license under subsection (1)(e)~~
23 ~~without conducting an investigation pursuant to 37-1-203 or making a written finding pursuant to~~
24 ~~37-1-204."~~

25
26 **Section 54.** Section 33-18-212, MCA, is amended to read:

27 **"33-18-212. Illegal dealing in premiums -- improper charges for insurance.** (1) A person may not
28 willfully collect any sum as a premium or charge for insurance, ~~which insurance~~ that is not then provided
29 or is not in due course to be provided, {subject to acceptance of the risk by the insurer}, by an insurance
30 policy issued by an insurer as authorized by this code.

(2) A person may not willfully collect as a premium or charge for insurance any sum in excess of or less than the premium or charge applicable to ~~such~~ the insurance and, as specified in the policy, in accordance with the applicable classifications and rates ~~as~~ filed with ~~and or~~ approved by the commissioner; or in cases ~~where in which~~ classifications, premiums, or rates are not required by this code to be ~~so~~ filed ~~and or~~ approved, ~~such~~ the premiums and charges may not be in excess of or less than those specified in the policy and as fixed by the insurer. This provision may not ~~be deemed to~~ prohibit the charging and collection, by surplus lines insurance producers licensed under chapter 2, part 3, of the amount of applicable state and federal taxes in addition to the premium required by the insurer. ~~It~~ This provision may not ~~be considered to~~ prohibit the charging and collection, by a life insurer, of amounts actually to be expended for medical examination of an applicant for life insurance or for reinstatement of a life insurance policy.

(3) Each violation of this section is punishable under 33-1-104."

Section 55. Section 33-18-301, MCA, is amended to read:

"33-18-301. Prohibited relations with mortuaries. (1) ~~No A~~ A life insurer and its officers, employees, or representatives may not own, manage, supervise, operate, or maintain any mortuary, funeral, or undertaking establishment ~~or permit its officers, employees, or representatives to own, operate, maintain, or be employed in any such business~~ in Montana.

(2) ~~No A~~ A life insurer may not contract or agree with any funeral director, mortuary, or undertaker ~~to the effect that such the~~ funeral director, undertaker, or mortuary shall conduct the funeral or be named beneficiary of any person insured by ~~such the~~ insurer. This subsection does not prohibit a life insurer from making insurance, designated as funeral insurance, available.

(3) A funeral insurance policy and any solicitation material for the policy must clearly indicate that:

(a) the policy is a life insurance product;

(b) the applicant may designate the beneficiary, provided that there is an appropriate and insurable interest;

(c) the beneficiary may use the proceeds for any purpose; and

(d) any attempt by the insurer or its representative to have the insured designate a specific beneficiary, including but not limited to a funeral director, mortuary, or undertaker, constitutes a violation of this section punishable as a misdemeanor pursuant to subsection (4).

1 ~~(3)(4)~~ Each violation of this section constitutes a misdemeanor punishable by a fine of not more
2 than \$1,000 or by imprisonment for not more than 6 months or by both ~~such fine and imprisonment.~~"

3
4 **Section 56.** Section 33-22-131, MCA, is amended to read:

5 **"33-22-131. Coverage for phenylketonuria treatment.** (1) Each group or individual medical
6 expense disability policy, certificate of insurance, and membership contract that is delivered, issued for
7 delivery, renewed, extended, or modified in this state must provide coverage for the treatment of
8 phenylketonuria.

9 (2) For purposes of this section, "treatment" means licensed professional medical services under
10 the supervision of a physician and a dietary formula product to achieve and maintain normalized blood levels
11 of phenylalanine and adequate nutritional status.

12 (3) These services are subject to the terms of the applicable group or individual disability policy,
13 certificate, or membership contract that establishes durational limits, dollar limits, deductibles, and
14 copayment provisions as long as the terms are not less favorable than for physical illness generally.

15 (4) This section does not apply to disability income, hospital indemnity, medicare supplement,
16 accident-only, vision, dental, or specified disease policies."

17
18 **Section 57.** Section 33-22-132, MCA, is amended to read:

19 **"33-22-132. Coverage for mammography examinations.** (1) Each group or individual medical
20 expense, cancer, hospital indemnity, and blanket disability policy, certificate of insurance, and membership
21 contract that is delivered, issued for delivery, renewed, extended, or modified in this state must provide
22 minimum mammography examination coverage.

23 (2) For the purpose of this section, "minimum mammography examination" means:

24 (a) one baseline mammogram for a woman who is 35 years of age or older and under 40 years of
25 age;

26 (b) a mammogram every 2 years for any woman who is 40 years of age or older and under 50
27 years of age or more frequently if recommended by the woman's physician; and

28 (c) a mammogram each year for a woman who is 50 years of age or older.

29 (3) A minimum \$70 payment or the actual charge if the charge is less than \$70 must be made for
30 each mammography examination performed before the application of the terms of the applicable group or

individual disability policy, certificate of insurance, or membership contract that establish durational limits, deductibles, and copayment provisions as long as the terms are not less favorable than for physical illness generally.

(4) This section does not apply to disability income, hospital indemnity, medicare supplement, accident-only, vision, dental, or specified disease policies."

Section 58. Section 33-22-201, MCA, is amended to read:

"33-22-201. Format and content. A An individual policy of disability insurance may not be delivered or issued for delivery to any person in this state unless it otherwise complies with this code and complies with the following:

(1) The entire money and other considerations for the policy must be expressed in the policy.

(2) The time when the insurance takes effect and terminates must be expressed in the policy.

(3) The policy may insure only one person, except that a policy may insure, originally or by subsequent amendment, upon the application of an adult member of a family who is the policyholder, any two or more eligible members of that family, including husband, wife, dependent children or any children under a specified age that may not exceed ~~19~~ 25 years, and any other person dependent upon the policyholder.

(4) The style, arrangement, and overall appearance of the policy may not give undue prominence to any portion of the text, and every printed portion of the text of the policy and of any endorsements or attached papers must be plainly printed in lightfaced type of a style in general use, the size of which must be uniform and not less than 10 point with a lowercase, unspaced alphabet length not less than 120 point.

(5) The "text" must include all printed matter except the name and address of the insurer, name or title of the policy, the brief description, if any, and captions and subcaptions.

(6) The exceptions and reductions of indemnity must be set forth in the policy and, other than those contained in 33-22-204 through 33-22-215 and ~~33-22-217~~ 33-22-221 through 33-22-231, must be printed, at the insurer's option, either included with the benefit provision to which they apply or under an appropriate caption such as "Exceptions" or "Exceptions and Reductions", except that if an exception or reduction specifically applies only to a particular benefit of the policy, a statement of the exception or reduction must be included with the benefit provision to which it applies.

~~(7) Each form, including riders and endorsements, must be identified by a form number in the lower~~

1 ~~left hand corner of the first page of the form.~~

2 ~~(8)(7)~~ The policy may not contain a provision purporting to make any portion of the charter, rules,
3 constitution, or bylaws of the insurer a part of the policy unless the portion is set forth in full in the policy,
4 except in the case of the incorporation of or reference to a statement of rates or classification of risks or
5 short-rate table filed with the commissioner.

6 ~~(9) Each individual disability policy, except for a single premium nonrenewable policy, issued for~~
7 ~~delivery in this state on or after January 1, 1980, must contain a notice stating in substance that if the~~
8 ~~person to whom the policy is issued is not satisfied for any reason, the person is permitted to return the~~
9 ~~policy within 10 days of its delivery, or a longer period as the policy may provide, and to have refunded~~
10 ~~the amount of the premium paid. A policy returned pursuant to this subsection is void from the beginning."~~

11
12 **Section 59.** Section 33-22-202, MCA, is amended to read:

13 **"33-22-202. Required provisions -- captions -- omissions -- substitutions -- order.** (1) Except as
14 provided in subsection (2), each policy delivered or issued for delivery to any person in this state must
15 contain the provisions specified in 33-22-204 through 33-22-215, ~~in the words in which the~~ as those
16 provisions appear, except that the insurer may, at its option, substitute for one or more of the provisions
17 corresponding provisions of different wording approved by the commissioner ~~which are in each instance~~
18 and not less favorable in any respect to the insured or the beneficiary. Each provision must be preceded
19 ~~individually~~ by the applicable caption shown or, at the option of the insurer, by the appropriate individual
20 or group captions or subcaptions as the commissioner may approve.

21 (2) If any provision is in whole or in part inapplicable to or inconsistent with the coverage provided
22 by a particular form of policy, the insurer, with the approval of the commissioner, shall omit from the policy
23 any inapplicable provision or part of a provision and shall modify any inconsistent provision or part of a
24 provision in a manner as to make the provision as contained in the policy consistent with the coverage
25 provided by the policy.

26 (3) The provisions that are the subject of 33-22-204 through 33-22-215 and ~~33-22-217~~ 33-22-221
27 through 33-22-232 or any corresponding provisions which are used in accordance with the cited sections
28 must be printed in the consecutive order of the provisions in the sections or, at the option of the insurer,
29 any provision may appear as a unit in any part of the policy with other provisions to which it may be
30 logically related, provided that the resulting policy is not in whole or in part unintelligible, uncertain,

1 ambiguous, abstruse, or likely to mislead a person to whom the policy is offered, delivered, or issued."

2
3 **Section 60.** Section 33-22-301, MCA, is amended to read:

4 **"33-22-301. Coverage of newborn under disability policy.** (1) Each policy of disability insurance
5 or certificate issued ~~thereunder shall~~ must contain a provision granting immediate accident and sickness
6 coverage, from and after the moment of birth, to each newborn infant of any insured.

7 (2) The coverage for newborn infants must be the same as provided by the policy for the other
8 covered persons; ~~provided, however~~ However, that for newborn infants there ~~shall be no~~ may not be
9 waiting or elimination periods. A deductible or reduction in benefits applicable to the coverage for newborn
10 infants is not permissible unless it conforms and is consistent with the deductible or reduction in benefits
11 applicable to all other covered persons.

12 (3) ~~No~~ A policy or certificate of insurance may not be issued or amended in this state if it contains
13 any disclaimer, waiver, or other limitation of coverage relative to the accident and sickness coverage or
14 insurability of newborn infants of an insured from and after the moment of birth.

15 (4) ~~If payment of a specific premium or subscription fee is required to provide coverage for a child,~~
16 ~~the policy or contract may require that notification of birth of a newly born child and payment of the~~
17 ~~required premium or fees must be furnished to the insurer or nonprofit service or indemnity corporation~~
18 ~~within 31 days after the date of birth in order to have the coverage continue beyond such 31-day period.~~
19 The policy or contract may require notification of the birth of a child and payment of a required premium
20 or subscription fee to be furnished to the insurer or nonprofit or indemnity corporation within 31 days of
21 the birth in order to have the coverage extend beyond 31 days."
22

23 **Section 61.** Section 33-22-303, MCA, is amended to read:

24 **"33-22-303. Coverage for well-child care.** (1) Each medical expense policy of disability insurance
25 or certificate issued under the policy that is delivered, issued for delivery, renewed, extended, or modified
26 in this state by a disability insurer and that provides coverage for a family member of the insured or
27 subscriber must provide coverage for well-child care for children from the moment of birth through 2 years
28 of age. Benefits provided under this coverage are exempt from any deductible provision that may be in
29 force in the policy or certificate issued under the policy.

30 (2) Coverage for well-child care under subsection (1) must include:

1 (a) a history, physical examination, developmental assessment, anticipatory guidance, and
2 laboratory tests, according to the schedule of visits adopted under the early and periodic screening,
3 diagnosis, and treatment services program provided for in 53-6-101; and

4 (b) routine immunizations according to the schedule for immunizations recommended by the
5 immunization practices advisory committee of the U.S. department of health and human services.

6 (3) Minimum benefits may be limited to one visit payable to one provider for all of the services
7 provided at each visit cited in this section.

8 (4) This section does not apply to disability income, specified disease, medicare supplement, or
9 hospital indemnity policies.

10 (5) For purposes of this section:

11 (a) "well-child care" means the services described in subsection (2) and delivered by a physician
12 or a health care professional supervised by a physician; and

13 (b) "developmental assessment" and "anticipatory guidance" mean the services described in the
14 Guidelines for Health Supervision II, published by the American academy of pediatrics.

15 (6) When a policy of disability insurance or a certificate issued under the policy provides coverage
16 or benefits to a resident of this state, it is considered to be delivered in this state within the meaning of this
17 section, whether the insurer that issued or delivered the policy or certificate is located inside or outside of
18 this state."

19

20 **Section 62.** Section 33-22-504, MCA, is amended to read:

21 **"33-22-504. Newborn infant coverage.** (1) ~~No A group disability policy or certificate of insurance~~
22 ~~which, in addition to covering persons in the insured group, also covers members of such person's family~~
23 ~~delivered or issued for delivery in this state~~ may not be issued or amended in this state if it contains any
24 disclaimer, waiver, or other limitation of coverage relative to the accident and sickness coverage or
25 insurability of newborn infants of persons covered under the policy from and after the moment of birth.

26 (2) ~~If the A policy or certificate issued thereunder, in addition to covering persons in the insured~~
27 ~~group, also covers members of such person's family, it shall~~ subject to this section, must contain an
28 ~~additional a~~ provision granting immediate accident and sickness coverage, from and after the moment of
29 birth, to each newborn infant of any person covered under the policy.

30 (3) The coverage for newborn infants ~~shall~~ must be the same as provided by the policy for other

covered persons; ~~provided, however~~ However, that for newborn infants there ~~shall~~ may not be ~~no~~ waiting or elimination periods. A deductible or reduction in benefits applicable to the coverage for newborn infants is not permissible unless it conforms and is consistent with the deductible or reduction in benefits applicable to all other covered persons.

(4) This section does not apply to medicare supplement policies issued by reason of age.

(5) When a group disability policy or certificate issued under the policy provides for coverage or benefits for a resident of this state, the policy or certificate is considered delivered in this state within the meaning of this section regardless of whether the insurer issuing the policy or certificate is located in this state.

(6) The policy or certificate may require notification of the birth of a child and payment of a required premium or subscription fee to be furnished to the insurer or nonprofit or indemnity corporation within 31 days of the birth in order to have the coverage extend beyond 31 days."

Section 63. Section 33-22-508, MCA, is amended to read:

"33-22-508. Conversion on termination of eligibility. (1) A group disability insurance policy or certificate of insurance delivered or issued for delivery or renewed after October 1, 1981, must contain a provision that if the insurance or any portion of it on a person, ~~his~~ or the person's dependents, or family members covered under the policy ceases because of termination of ~~his~~ the person's employment or of ~~his~~ the person's membership in the class or classes eligible for coverage under the policy or as a result of ~~his~~ the person's employer discontinuing ~~his~~ the business or as a result of ~~his~~ the employer discontinuing the group disability insurance policy and not providing for any other group disability insurance or plan and if the person had been insured for a period of 3 months and ~~he~~ is not insured under another major medical disability insurance policy or plan, ~~he~~ the person is entitled to have issued ~~to him~~ by the insurer, without evidence of insurability, group coverage or an individual policy ~~issued by the insurer~~ or, in the absence of an individual policy issued by the insurer, a group policy issued by the insurer, of hospital or medical service insurance on ~~himself~~ the person, ~~his~~ and the person's dependents, or family members if application for the individual policy is made and the first premium tendered to the insurer within 31 days after the termination of group coverage.

(2) The individual policy or group policy, at the option of the insured, may be on any form then customarily issued by the insurer to individual or group policyholders, with the exception of a policy the

1 eligibility for which is determined by affiliation other than by employment with a common entity.

2 (3) The premium on the individual policy or group policy must be at the insurer's then customary
3 rate applicable to the coverage of the individual or group policy."

4

5 **Section 64.** Section 33-22-1120, MCA, is amended to read:

6 **"33-22-1120. Extraterritorial jurisdiction.** A group long-term care insurance policy or certificate
7 may not be delivered or issued for delivery to a resident of Montana under a group policy issued in another
8 state ~~to a group described in 33-22-1107(3)(d)~~ unless it is approved by:

9 (1) the commissioner; ~~or~~ and

10 (2) the insurance regulatory official of a state that has statutory and regulatory long-term care
11 insurance requirements substantially similar to those adopted in Montana."

12

13 **Section 65.** Section 33-22-1803, MCA, is amended to read:

14 **"33-22-1803. Definitions.** As used in this part, the following definitions apply:

15 (1) "Actuarial certification" means a written statement by a member of the American academy of
16 actuaries or other individual acceptable to the commissioner that a small employer carrier is in compliance
17 with the provisions of 33-22-1809, based upon the person's examination, including a review of the
18 appropriate records and of the actuarial assumptions and methods used by the small employer carrier in
19 establishing premium rates for applicable health benefit plans.

20 (2) "Affiliate" or "affiliated" means any entity or person who directly or indirectly, through one or
21 more intermediaries, controls, is controlled by, or is under common control with a specified entity or person.

22 (3) "Assessable carrier" means all individual carriers of disability insurance and all carriers of group
23 disability insurance, excluding the state group benefits plan provided for in Title 2, chapter 18, part 8, the
24 Montana university system health plan, and any self-funded disability insurance plan provided by a political
25 subdivision of the state.

26 (4) "Base premium rate" means, for each class of business as to a rating period, the lowest
27 premium rate charged or that could have been charged under the rating system for that class of business
28 by the small employer carrier to small employers with similar case characteristics for health benefit plans
29 with the same or similar coverage.

30 (5) "Basic health benefit plan" means a lower cost health benefit plan developed pursuant to

1 33-22-1812.

2 (6) "Board" means the board of directors of the program established pursuant to 33-22-1818.

3 (7) "Carrier" means any person who provides a health benefit plan in this state subject to state
4 insurance regulation. The term includes but is not limited to an insurance company, a fraternal benefit
5 society, a health service corporation, a health maintenance organization, and, to the extent permitted by
6 the Employee Retirement Income Security Act of 1974, a multiple-employer welfare arrangement. For
7 purposes of this part, companies that are affiliated companies or that are eligible to file a consolidated tax
8 return must be treated as one carrier, except that the following may be considered as separate carriers:

9 (a) an insurance company or health service corporation that is an affiliate of a health maintenance
10 organization located in this state;

11 (b) a health maintenance organization located in this state that is an affiliate of an insurance
12 company or health service corporation; or

13 (c) a health maintenance organization that operates only one health maintenance organization in
14 an established geographic service area of this state.

15 (8) "Case characteristics" means demographic or other objective characteristics of a small employer
16 that are considered by the small employer carrier in the determination of premium rates for the small
17 employer, provided that gender, claims experience, health status, and duration of coverage are not case
18 characteristics for purposes of this part.

19 (9) "Class of business" means all or a separate grouping of small employers established pursuant
20 to 33-22-1808.

21 (10) "Committee" means the health benefit plan committee created pursuant to 33-22-1812.

22 (11) "Dependent" means:

23 (a) a spouse or an unmarried child under 19 years of age;

24 (b) an unmarried child, under 23 years of age, who is a full-time student and who is financially
25 dependent on the insured;

26 (c) a child of any age who is disabled and dependent upon the parent as provided in 33-22-506
27 and 33-30-1003; or

28 (d) any other individual defined ~~to be~~ as a dependent in the health benefit plan covering the
29 employee.

30 (12) "Eligible employee" means an employee who works on a full-time basis and who has a normal

workweek of 30 hours or more. The term includes a sole proprietor, a partner of a partnership, and an independent contractor if the sole proprietor, partner, or independent contractor is included as an employee under a health benefit plan of a small employer. The term does not include an employee who works on a part-time, temporary, or substitute basis.

(13) "Established geographic service area" means a geographic area, as approved by the commissioner and based on the carrier's certificate of authority to transact insurance in this state, within which the carrier is authorized to provide coverage.

(14) "Health benefit plan" means any hospital or medical policy or certificate providing for physical and mental health care issued by an insurance company, a fraternal benefit society, or a health service corporation or issued under a health maintenance organization subscriber contract. Health benefit plan does not include:

(a) accident-only, credit, dental, vision, specified disease, medicare supplement, long-term care, or disability income insurance;

(b) coverage issued as a supplement to liability insurance, workers' compensation insurance, or similar insurance; or

(c) automobile medical payment insurance.

(15) "Index rate" means, for each class of business for a rating period for small employers with similar case characteristics, the average of the applicable base premium rate and the corresponding highest premium rate.

(16) "Late enrollee" means an eligible employee or dependent who requests enrollment in a health benefit plan of a small employer following the initial enrollment period during which the individual was entitled to enroll under the terms of the health benefit plan, provided that the initial enrollment period was a period of at least 30 days. However, an eligible employee or dependent may not be considered a late enrollee if:

(a) the individual requests enrollment within 30 days after termination of the qualifying previous coverage and ~~meets each of the following conditions:~~

(i) the individual was covered under qualifying previous coverage at the time of the initial enrollment; or

(ii) the individual lost coverage under qualifying previous coverage as a result of termination of employment or eligibility, the involuntary termination of the qualifying previous coverage, the death of a

1 spouse, or divorce; and

2 ~~(iii) the individual requests enrollment within 30 days after termination of the qualifying previous~~
3 ~~coverage;~~

4 (b) the individual is employed by an employer that offers multiple health benefit plans and the
5 individual elects a different plan during an open enrollment period; or

6 (c) a court has ordered that coverage be provided for a spouse, minor, or dependent child under
7 a covered employee's health benefit plan and a request for enrollment is made within 30 days after issuance
8 of the court order.

9 (17) "New business premium rate" means, for each class of business for a rating period, the lowest
10 premium rate charged or offered or that could have been charged or offered by the small employer carrier
11 to small employers with similar case characteristics for newly issued health benefit plans with the same or
12 similar coverage.

13 (18) "Plan of operation" means the operation of the program established pursuant to 33-22-1818.

14 (19) "Premium" means all money paid by a small employer and eligible employees as a condition
15 of receiving coverage from a small employer carrier, including any fees or other contributions associated
16 with the health benefit plan.

17 (20) "Program" means the Montana small employer health reinsurance program created by
18 33-22-1818.

19 (21) "Qualifying previous coverage" means benefits or coverage provided under:

20 (a) medicare or medicaid;

21 (b) an employer-based health insurance or health benefit arrangement that provides benefits similar
22 to or exceeding benefits provided under the basic health benefit plan; or

23 (c) an individual health insurance policy, including coverage issued by an insurance company, a
24 fraternal benefit society, a health service corporation, or a health maintenance organization that provides
25 benefits similar to or exceeding the benefits provided under the basic health benefit plan, provided that the
26 policy has been in effect for a period of at least 1 year.

27 (22) "Rating period" means the calendar period for which premium rates established by a small
28 employer carrier are assumed to be in effect.

29 (23) "Reinsuring carrier" means a small employer carrier participating in the reinsurance program
30 pursuant to 33-22-1819.

1 (24) "Restricted network provision" means a provision of a health benefit plan that conditions the
2 payment of benefits, in whole or in part, on the use of health care providers that have entered into a
3 contractual arrangement with the carrier pursuant to Title 33, chapter 22, part 17, or Title 33, chapter 31,
4 to provide health care services to covered individuals.

5 (25) "Small employer" means a person, firm, corporation, partnership, or association that is actively
6 engaged in business and that, on at least 50% of its working days during the preceding calendar quarter,
7 employed at least 3 but not more than 25 eligible employees, the majority of whom were employed within
8 this state or were residents of this state. In determining the number of eligible employees, companies are
9 considered one employer if they:

10 (a) are affiliated companies;

11 (b) are eligible to file a combined tax return for purposes of state taxation; or

12 (c) are members of an association that:

13 (i) has been in existence for 1 year prior to January 1, 1994;

14 (ii) provides a health benefit plan to employees of its members as a group; and

15 (iii) does not deny coverage to any member of its association or any employee of its members who
16 applies for coverage as part of a group.

17 (26) "Small employer carrier" means a carrier that offers health benefit plans that cover eligible
18 employees of one or more small employers in this state.

19 (27) "Standard health benefit plan" means a health benefit plan developed pursuant to
20 33-22-1812."
21

22 **Section 66.** Section 33-22-1819, MCA, is amended to read:

23 **"33-22-1819. Program plan of operation -- treatment of losses -- exemption from taxation. (1)**

24 Within 180 days after the appointment of the initial board, the board shall submit to the commissioner a
25 plan of operation and may at any time submit amendments to the plan necessary or suitable to ensure the
26 fair, reasonable, and equitable administration of the program. The commissioner may, after notice and
27 hearing, approve the plan of operation if the commissioner determines it to be suitable to ensure the fair,
28 reasonable, and equitable administration of the program and if the plan of operation provides for the sharing
29 of program gains or losses on an equitable and proportionate basis in accordance with the provisions of this
30 section. The plan of operation is effective upon written approval by the commissioner.

1 (2) If the board fails to submit a suitable plan of operation within 180 days after its appointment,
2 the commissioner shall, after notice and hearing, promulgate and adopt a temporary plan of operation. The
3 commissioner shall amend or rescind any temporary plan adopted under this subsection at the time a plan
4 of operation is submitted by the board and approved by the commissioner.

5 (3) The plan of operation must:

6 (a) establish procedures for the handling and accounting of program assets and money and for an
7 annual fiscal reporting to the commissioner;

8 (b) establish procedures for selecting an administering carrier and setting forth the powers and
9 duties of the administering carrier;

10 (c) establish procedures for reinsuring risks in accordance with the provisions of this section;

11 (d) establish procedures for collecting assessments from assessable carriers to fund claims incurred
12 by the program;

13 (e) establish procedures for allocating a portion of premiums collected from reinsuring carriers to
14 fund administrative expenses incurred or to be incurred by the program; and

15 (f) provide for any additional matters necessary for the implementation and administration of the
16 program.

17 (4) The program has the general powers and authority granted under the laws of this state to
18 insurance companies and health maintenance organizations licensed to transact business, except the power
19 to issue health benefit plans directly to either groups or individuals. In addition, the program may:

20 (a) enter into contracts as are necessary or proper to carry out the provisions and purposes of this
21 part, including the authority, with the approval of the commissioner, to enter into contracts with similar
22 programs of other states for the joint performance of common functions or with persons or other
23 organizations for the performance of administrative functions;

24 (b) sue or be sued, including taking any legal actions necessary or proper to recover any premiums
25 and penalties for, on behalf of, or against the program or any reinsuring carriers;

26 (c) take any legal action necessary to avoid the payment of improper claims against the program;

27 (d) define the health benefit plans for which reinsurance will be provided and to issue reinsurance
28 policies in accordance with the requirements of this part;

29 (e) establish conditions and procedures for reinsuring risks under the program;

30 (f) establish actuarial functions as appropriate for the operation of the program;

1 (g) appoint appropriate legal, actuarial, and other committees as necessary to provide technical
2 assistance in operation of the program, policy and other contract design, and any other function within the
3 authority of the program;

4 (h) to the extent permitted by federal law and in accordance with subsection (8)(c), make annual
5 fiscal yearend assessments against assessable carriers and make interim assessments to fund claims
6 incurred by the program; and

7 (i) borrow money to effect the purposes of the program. Any notes or other evidence of
8 indebtedness of the program not in default are legal investments for carriers and may be carried as admitted
9 assets.

10 (5) A reinsuring carrier may reinsure with the program as provided for in this subsection (5):

11 (a) With respect to a basic health benefit plan or a standard health benefit plan, the program shall
12 reinsure the level of coverage provided and, with respect to other plans, the program shall reinsure up to
13 the level of coverage provided in a basic or standard health benefit plan.

14 (b) A small employer carrier may reinsure an entire employer group within 60 days of the
15 commencement of the group's coverage under a health benefit plan.

16 (c) A reinsuring carrier may reinsure an eligible employee or dependent within a period of 60 days
17 following the commencement of coverage with the small employer. A newly eligible employee or dependent
18 of the reinsured small employer may be reinsured within 60 days of the commencement of coverage.

19 (d) (i) The program may not reimburse a reinsuring carrier with respect to the claims of a reinsured
20 employee or dependent until the carrier has incurred an initial level of claims for the employee or dependent
21 of \$5,000 in a calendar year for benefits covered by the program. In addition, the reinsuring carrier is
22 responsible for 20% of the next \$100,000 of benefit payments during a calendar year and the program
23 shall reinsure the remainder. A reinsuring carrier's liability under this subsection (d)(i) may not exceed a
24 maximum limit of \$25,000 in any calendar year with respect to any reinsured individual.

25 (ii) The board annually shall adjust the initial level of claims and maximum limit to be retained by
26 the carrier to reflect increases in costs and utilization within the standard market for health benefit plans
27 within the state. The adjustment may not be less than the annual change in the medical component of the
28 consumer price index for all urban consumers of the United States department of labor, bureau of labor
29 statistics, unless the board proposes and the commissioner approves a lower adjustment factor.

30 (e) A small employer carrier may terminate reinsurance with the program for one or more of the

1 reinsured employees or dependents of a small employer on any anniversary of the health benefit plan.

2 (f) A small employer group health benefit plan in effect before January 1, 1994, may not be
3 reinsured by the program until January 1, 1997, and then only if the board determines that sufficient
4 funding sources are available.

5 (g) A reinsuring carrier shall apply all managed care and claims-handling techniques, including
6 utilization review, individual case management, preferred provider provisions, and other managed care
7 provisions or methods of operation consistently with respect to reinsured and nonreinsured business.

8 (6) (a) As part of the plan of operation, the board shall establish a methodology for determining
9 premium rates to be charged by the program for reinsuring small employers and individuals pursuant to this
10 section. The methodology must include a system for classification of small employers that reflects the types
11 of case characteristics commonly used by small employer carriers in the state. The methodology must
12 provide for the development of base reinsurance premium rates that must be multiplied by the factors set
13 forth in subsection (6)(b) to determine the premium rates for the program. The base reinsurance premium
14 rates must be established by the board, subject to the approval of the commissioner, and must be set at
15 levels that reasonably approximate gross premiums charged to small employers by small employer carriers
16 for health benefit plans with benefits similar to the standard health benefit plan, adjusted to reflect retention
17 levels required under this part.

18 (b) Premiums for the program are as follows:

19 (i) An entire small employer group may be reinsured for a rate that is one and one-half times the
20 base reinsurance premium rate for the group established pursuant to this subsection (6).

21 (ii) An eligible employee or dependent may be reinsured for a rate that is five times the base
22 reinsurance premium rate for the individual established pursuant to this subsection (6).

23 (c) The board periodically shall review the methodology established under subsection (6)(a),
24 including the system of classification and any rating factors, to ensure that it reasonably reflects the claims
25 experience of the program. The board may propose changes to the methodology that are subject to the
26 approval of the commissioner.

27 (d) The board may consider adjustments to the premium rates charged by the program to reflect
28 the use of effective cost containment and managed care arrangements.

29 (7) If a health benefit plan for a small employer is entirely or partially reinsured with the program,
30 the premium charged to the small employer for any rating period for the coverage issued must meet the

1 requirements relating to premium rates set forth in 33-22-1809.

2 (8) (a) Prior to March 1 of each year, the board shall determine and report to the commissioner the
3 program net loss for the previous calendar year, including administrative expenses and incurred losses for
4 the year, taking into account investment income and other appropriate gains and losses.

5 (b) To the extent permitted by federal law, each assessable carrier shall share in any net loss of
6 the program for the year in an amount equal to the ratio of the total premiums earned in the previous
7 calendar year from health benefit plans delivered or issued for delivery by each assessable carrier divided
8 by the total premiums earned in the previous calendar year from health benefit plans delivered or issued
9 for delivery by all assessable carriers in the state.

10 (c) The board shall make an annual determination in accordance with this section of each
11 assessable carrier's liability for its share of the net loss of the program and, except as otherwise provided
12 by this section, make an annual fiscal yearend assessment against each assessable carrier to the extent of
13 that liability. If approved by the commissioner, the board may also make interim assessments against
14 assessable carriers to fund claims incurred by the program. Any interim assessment must be credited
15 against the amount of any fiscal yearend assessment due or to be due from an assessable carrier. Payment
16 of a fiscal yearend or interim assessment is due within 30 days of receipt by the assessable carrier of
17 written notice of the assessment. An assessable carrier that ceases doing business within the state is liable
18 for assessments until the end of the calendar year in which the assessable carrier ceased doing business.
19 The board may determine not to assess an assessable carrier if the assessable carrier's liability determined
20 in accordance with this section does not exceed \$10.

21 (9) The participation in the program as reinsuring carriers; the establishment of rates, forms, or
22 procedures; or any other joint collective action required by this part may not be the basis of any legal
23 action, criminal or civil liability, or penalty against the program or any of its reinsuring carriers, either jointly
24 or separately.

25 (10) The board, as part of the plan of operation, shall develop standards setting forth the minimum
26 levels of compensation to be paid to producers for the sale of basic and standard health benefit plans. In
27 establishing the standards, the board shall take into consideration the need to ensure the broad availability
28 of coverages, the objectives of the program, the time and effort expended in placing the coverage, the need
29 to provide ongoing service to small employers, the levels of compensation currently used in the industry,
30 and the overall costs of coverage to small employers selecting these plans.

1 (11) The program is exempt from taxation.

2 (12) On or before March 1 of each year, the commissioner shall evaluate the operation of the
3 program and report to the governor and the legislature in writing the results of the evaluation. The report
4 must include an estimate of future costs of the program, assessments necessary to pay those costs, the
5 appropriateness of premiums charged by the program, the level of insurance retention under the program,
6 the cost of coverage of small employers, and any recommendations for change to the plan of operation.

7 (13) All premiums and other money paid to the small employer carrier reinsurance program and all
8 property and securities acquired through the use of money and interest and dividends earned on money
9 belonging to the small employer carrier reinsurance program are solely the property of the program and
10 must be used exclusively for the operations and obligations of the program. Money collected by the
11 program is not subject to legislative appropriation."

12
13 **Section 67.** Section 33-30-102, MCA, is amended to read:

14 **"33-30-102. Application of this chapter -- construction of other related laws.** (1) All health service
15 corporations ~~heretofore or hereafter organized~~ are subject to the provisions of this chapter. In addition to
16 the provisions contained in this chapter, other chapters and provisions of this title apply to health service
17 corporations as follows: ~~33-17-212 33-17-101; through 33-17-214~~ Title 33, chapter 17, parts 2 and 10
18 through 12; and Title 33, chapters 1, 15, 18, 19, and 22, except 33-22-111; and [sections 78 through 81].

19 (2) A law of this state other than the provisions of this chapter applicable to health service
20 corporations ~~shall~~ must be construed in accordance with the fundamental nature of a health service
21 corporation, and in the event of a conflict ~~between that law and the provisions of this chapter, the latter~~
22 ~~shall~~ prevail."

23
24 **Section 68.** Section 33-30-107, MCA, is amended to read:

25 **"33-30-107. Annual statement.** (1) On or before March 1 of each year, Every each health service
26 corporation shall file an annual statement for the preceding year on a form containing substantially the same
27 ~~information as that contained in form No. 13 N.A.I.C. with the commissioner of insurance. This annual~~
28 statement must be completed in accordance with the national association of insurance commissioners'
29 annual statement instructions.

30 (2) The health service corporation shall file a statement containing any other information concerning

1 its financial affairs that may be reasonably requested by the commissioner.

2 (3) (a) Each health service corporation shall file electronic diskette versions of its annual and
 3 quarterly financial statements with the national association of insurance commissioners. The filing date for
 4 submission of the annual statement diskette is March 1. The filing dates for the other three quarterly
 5 statements are as follows:

6 (i) the first quarter statement is due May 15;

7 (ii) the second quarter statement is due August 15; and

8 (iii) the third quarter statement is due November 15.

9 (b) The commissioner may exempt health service corporations operating only in Montana from
 10 these filing requirements."

11
 12 **Section 69.** Section 33-30-108, MCA, is amended to read:

13 **"33-30-108. License required.** (1) ~~Ne~~ A person may not act as a health service corporation and
 14 ~~ne~~ a health service corporation may not conduct business in this state except as authorized by a license
 15 issued by the commissioner.

16 (2) ~~Such~~ A license may be issued by the commissioner only after the person has complied with the
 17 applicable provisions of this title.

18 (3) A health service corporation is entitled to a continuation of its license upon payment of the
 19 annual continuation fee specified in 33-30-204(1)(i) on or before March 1 of each year and upon continued
 20 compliance with the provisions of this title.

21 (4) A license issued or continued under this section may be revoked or suspended by the
 22 commissioner for violation of this title."

23
 24 **Section 70.** Section 33-30-202, MCA, is amended to read:

25 **"33-30-202. Annual report by certified public accountant.** (1) All corporations subject to the
 26 provisions of this chapter shall ~~make and~~ file annually with the commissioner, on or before ~~March~~ June 1
 27 ~~of each year, a report under oath setting forth:~~ financial statement audited by a certified public accountant
 28 pursuant to rules promulgated by the commissioner.

29 ~~(1) the name of the corporation;~~

30 ~~(2) the address of its registered office in this state and the name of its registered agent at that~~

1 address;

2 ~~(3) the names and addresses of its directors and officers;~~

3 ~~(4) a brief statement of the character of the affairs which the corporation is actually conducting;~~

4 ~~(5) the amount of all dues or fees collected from members in the last fiscal year, the amounts~~
5 ~~actually paid during that year for health services for the members or beneficiaries, and the amounts placed~~
6 ~~in reserves;~~

7 ~~(6) a balance sheet and statement of income and expenditures for the most recent fiscal year of~~
8 ~~the corporation, prepared and verified by two officers of the corporation and certified by a certified public~~
9 ~~accountant;~~

10 ~~(7) a statement of any other facts or information concerning the financial affairs of the health~~
11 ~~service corporation which may be reasonably required by the commissioner.~~

12 (2) (a) The commissioner may establish rules governing the content and preparation of the report
13 required by subsection (1).

14 (b) The report must include:

15 (i) the corporation's financial statements for the most recent calendar year;

16 (ii) an opinion by the certified public accountant concerning the accuracy and fairness of the
17 corporation's representation of its financial statements; and

18 (iii) other information that the commissioner specifies by rule."

19
20 **Section 71.** Section 33-30-204, MCA, is amended to read:

21 **"33-30-204. Fees.** (1) Every health service corporation subject to the provisions of this chapter
22 shall pay the following fees to the commissioner for enforcement of the provisions of this chapter:

23 ~~(a) insurance producer's license:~~

24 ~~(i) application for original license and issuance of license \$15~~

25 ~~(ii) annual renewal \$15~~

26 ~~(iii) examination for license, for each examination \$15~~

27 ~~(b)(a)~~ filing any other statement or report \$1

28 ~~(b)~~ for a certified copy of any document or other paper filed in the office of the commissioner,
29 per page \$.50

30 ~~(c)~~ for the a certificate and for affixing the with affixed seal thereto \$10

~~(e)~~(d) filing of a membership contract \$25

~~(f)~~(e) filing of a membership contract package \$100

~~(g)~~(f) filing annual report, other than as part of application for original license STATEMENT \$25

~~(h)~~(g) issuance of health service corporation license \$300

~~(i)~~(h) annual continuation of health service corporation license \$300

(2) The commissioner shall promptly deposit with the state treasurer, to the credit of the general fund, all fees and license fees received ~~by him~~ under this section."

Section 72. Section 33-30-311, MCA, is amended to read:

"33-30-311. Insurance producer. ~~(1)~~ A person who, for compensation, solicits membership in a prepayment health service plan offered by a corporation subject to the provisions of this chapter is an insurance producer of that corporation and is subject to the provisions of 33-2-708 and Title 33, chapter 17.

~~(2) The definitions of insurance producer as defined in this chapter do not include an individual:~~

~~(a) employed and used by insurance producers for the performance of clerical, stenographic, and similar office duties;~~

~~(b) employed and used for incidental taking of an application for coverage from time to time in the office of the employing insurance producer;~~

~~(c) who secures and forwards information for the purpose of an existing group contractor for enrolling individuals under an existing group contract."~~

Section 73. Section 33-30-1001, MCA, is amended to read:

"33-30-1001. Newborn infants covered by insurance by health service corporation. ~~No~~ A disability insurance plan or group disability insurance plan issued by a health service corporation may not be issued or amended in this state if it contains any disclaimer, waiver, or other limitation of coverage relative to the accident and sickness coverage or insurability of newborn infants of the persons insured from and after the moment of birth. Each ~~such~~ policy ~~shall~~ must contain a provision granting immediate accident and sickness coverage, from and after the moment of birth, to each newborn infant of any insured person. ~~If payment of a specific premium or subscription fee is required to provide coverage for a child, the policy or contract may require that notification of birth of a newly born child and payment of the required premium or fees~~

1 must be furnished to the insurer or nonprofit service or indemnity corporation within 31 days after the date
2 of birth in order to have the coverage continue beyond such 31 day period. The policy or contract may
3 require notification of the birth of a child and payment of a required premium or subscription fee to be
4 furnished to the insurer or nonprofit or indemnity corporation within 31 days of the birth in order to have
5 the coverage extend beyond 31 days."

6
7 **Section 74.** ~~Section 33-31-311, MCA, is amended to read:~~

8 ~~"33-31-311. Insurance producer license required—application, issuance, renewal, fees—penalty.~~

9 ~~(1) No An individual, partnership, or corporation may not act as or hold himself out represent to the public~~
10 ~~to be an insurance producer of a health maintenance organization unless he the individual, partnership, or~~
11 ~~corporation is:~~

12 ~~(a) licensed as a disability insurance producer by the commissioner pursuant to chapter 17, parts~~
13 ~~1, 2, and 4 of this title or licensed as an insurance producer under 33-30-311 through 33-30-313; and~~

14 ~~(b) appointed or authorized by the health maintenance organization to solicit health care service~~
15 ~~agreements on its behalf,~~

16 ~~(2) Application, appointment and qualification for a health maintenance organization insurance~~
17 ~~producer license, fees applicable to and the issuance of a health maintenance organization insurance~~
18 ~~producer license, and renewal of a health maintenance organization insurance producer license must be in~~
19 ~~accordance with the provisions of chapter 17 that apply to a disability insurance producer.~~

20 ~~(3) An individual, partnership, or corporation who holds a disability insurance producer license on~~
21 ~~October 1, 1987, need not requalify by an examination to be licensed as a health maintenance organization~~
22 ~~insurance producer.~~

23 ~~(4) The commissioner may, in accordance with 33-1-313, 33-1-317, 33-17-411, and chapter 17,~~
24 ~~part 10, suspend, revoke, refuse to issue or renew a health maintenance organization insurance producer~~
25 ~~license, or impose a fine upon the licensee.~~

26 ~~(5) The provisions of this section do not exempt a health maintenance organization from material~~
27 ~~transaction disclosure requirements under [sections 78 through 81]. A health maintenance organization~~
28 ~~must be considered an insurer for the purposes of [sections 78 through 81]."~~

29
30 **SECTION 74. SECTION 33-31-111, MCA, IS AMENDED TO READ:**

1 **"33-31-111. Statutory construction and relationship to other laws.** (1) Except as otherwise
2 provided in this chapter, the insurance or health service corporation laws do not apply to any health
3 maintenance organization authorized to transact business under this chapter. This provision does not apply
4 to an insurer or health service corporation licensed and regulated pursuant to the insurance or health service
5 corporation laws of this state except with respect to its health maintenance organization activities
6 authorized and regulated pursuant to this chapter.

7 (2) Solicitation of enrollees by a health maintenance organization granted a certificate of authority
8 or its representatives may not be construed as a violation of any law relating to solicitation or advertising
9 by health professionals.

10 (3) A health maintenance organization authorized under this chapter may not be considered to be
11 practicing medicine and is exempt from Title 37, chapter 3, relating to the practice of medicine.

12 (4) The provisions of this chapter do not exempt a health maintenance organization from the
13 applicable certificate of need requirements under Title 50, chapter 5, parts 1 and 3.

14 (5) The provisions of this section do not exempt a health maintenance organization from material
15 transaction disclosure requirements under [sections 78 through 81]. A health maintenance organization
16 must be considered an insurer for the purposes of [sections 78 through 81]."

17
18 **NEW SECTION. Section 75. Notice of right to return policy.** Each INDIVIDUAL life or disability
19 insurance policy, except a single-premium nonrenewable disability policy, issued for delivery in this state
20 or issued after January 1, 1996, must contain a notice stating in substance that if the person to whom the
21 policy is issued is not satisfied for any reason, the person may return the policy within 10 days of its
22 delivery or a longer period if provided by the policy and have refunded directly to the person the premium
23 paid. A policy returned pursuant to this section is void from the beginning.

24
25 **NEW SECTION. Section 76. Reserve calculation -- indeterminate premium plans -- minimum**
26 **standards for disability plans.** (1) In the case of a plan of life insurance that provides for future premium
27 determination, the amounts of which are to be determined by the insurer based on then estimates of future
28 experience, or in the case of a plan of life insurance or annuity that is of such a nature that the minimum
29 reserves cannot be determined by the methods described in 33-2-525 and 33-2-526(3), the reserves that
30 are held under the plan must:

1 (a) be appropriate in relation to the benefits and the pattern of premiums for that plan; and

2 (b) be computed by a method that is consistent with the principles of 33-2-521 through 33-2-529,
3 as determined by rules promulgated by the commissioner.

4 (2) The commissioner shall promulgate a rule containing the minimum standards applicable to the
5 valuation of disability plans.

6
7 **NEW SECTION.** **Section 77. Dating of insurance applications -- antedating prohibited.** An
8 application for issuance of an insurance policy may not be antedated by any person in order to obtain or
9 provide coverage for losses or injuries incurred prior to the date of application.

10
11 **NEW SECTION.** **Section 78. Short title.** [Sections 78 through 81] may be cited as the "Disclosure
12 of Material Transactions Act".

13
14 **NEW SECTION.** **Section 79. Report.** (1) An insurer domiciled in this state shall file a report with
15 the commissioner disclosing material acquisitions and dispositions of assets or material nonrenewals,
16 cancellations, or revisions of ceded reinsurance agreements unless the acquisitions and dispositions of
17 assets or material nonrenewals, cancellations, or revisions have been submitted to the commissioner for
18 review or approval or for information purposes pursuant to other provisions of the insurance code, laws,
19 or regulations or other requirements.

20 (2) The report required in subsection (1) is due within 15 days after the end of the calendar month
21 in which any of the transactions in subsection (1) occur.

22 (3) One complete copy of the report, including any exhibits or other attachments, must be filed
23 with:

24 (a) the insurance department of the state in which the insurer is domiciled; and

25 (b) the national association of insurance commissioners.

26 (4) All reports obtained by or disclosed to the commissioner pursuant to [sections 78 through 81]
27 must be treated confidentially, may not be subject to subpoena, and may not be made public by the
28 commissioner, the national association of insurance commissioners, or any other person, except to
29 insurance departments of other states, without the prior consent of the insurer to which it pertains unless
30 the commissioner, after giving the insurer notice and an opportunity to be heard, determines that the

1 interest of policyholders, shareholders, or the public will be served by publication, in which event the
2 commissioner may publish all or any part of the report in the manner the commissioner chooses.

3
4 NEW SECTION. **Section 80. Acquisitions and dispositions of assets.** (1) Acquisitions or
5 dispositions of assets that are not material are not required to be reported pursuant to [section 79] if the
6 acquisitions or dispositions are not material. For purposes of [sections 78 through 81], a material
7 acquisition or the aggregate of any series of related acquisitions during any 30-day period or a disposition
8 or the aggregate of any series of related dispositions during any 30-day period is one that is nonrecurring
9 and not in the ordinary course of business and involves more than 5% of the reporting insurer's total
10 admitted assets as reported in its most recent statutory statement filed with the insurance department of
11 the insurer's state of domicile.

12 (2) Asset acquisitions subject to [sections 78 through 81] include every purchase, lease, exchange,
13 merger, consolidation, succession, or other acquisition, other than the construction or development of real
14 property, by or for the reporting insurer or the acquisition of materials for this purpose.

15 (3) Asset dispositions subject to [sections 78 through 81] include each sale, lease, exchange,
16 merger, consolidation, mortgage, hypothecation, assignment, whether for the benefit of creditors or
17 otherwise, abandonment, destruction, or other disposition.

18 (4) The following information is required to be disclosed in any report of a material acquisition or
19 disposition of assets:

20 (a) the date of the transaction;

21 (b) the manner of acquisition or disposition;

22 (c) the description of the assets involved;

23 (d) the nature and amount of the consideration given or received;

24 (e) the purpose or reason for the transaction;

25 (f) the manner by which the amount of consideration was determined;

26 (g) the gain or loss recognized or realized as a result of the transaction; and

27 (h) the names of the persons from whom the assets were acquired or to whom they were disposed.

28 (5) An insurer is required to report material acquisitions and dispositions on a nonconsolidated basis
29 unless the insurer is part of a consolidated group of insurers that uses a pooling arrangement or 100%
30 reinsurance agreement that affects the solvency and integrity of the insurer's reserves and the insurer

ceded substantially all of its direct and assumed business to the pool. An insurer cedes substantially all of its direct and assumed business to a pool if the insurer has less than \$1 million total direct plus assumed written premiums during a calendar year that are not subject to a pooling arrangement and the net income of the business not subject to the pooling arrangement represents less than 5% of the insurer's capital and surplus.

NEW SECTION. Section 81. Nonrenewals, cancellations, or revisions of ceded reinsurance agreements. (1) A nonrenewal, cancellation, or revision of a ceded reinsurance agreement need not be reported pursuant to [section 79] if the nonrenewal, cancellation, or revision is not material. For purposes of [sections 78 through 81], a material nonrenewal, cancellation, or revision is one that affects:

(a) property and casualty business, including disability business written by a property and casualty insurer, so that:

(i) more than 50% of the insurer's total ceded written premium is affected; or

(ii) more than 50% of the insurer's total ceded indemnity and loss adjustment reserves are affected;

(b) life, annuity, and disability business, so that more than 50% of the total reserve credit taken for business ceded, on an annualized basis, as indicated in the insurer's most recent annual statement is affected;

(c) either property and casualty or life, annuity, and disability business and causes either of the following events that constitutes a material revision that must be reported:

(i) an authorized reinsurer representing more than 10% of a total cession is replaced by one or more unauthorized reinsurers; or

(ii) previously established collateral requirements have been reduced or waived as respects one or more unauthorized reinsurers representing collectively more than 10% of a total cession.

(2) However, a filing is not required if:

(a) with respect to property and casualty business, including disability business written by a property and casualty insurer, the insurer's total ceded written premium represents, on an annualized basis, less than 10% of its total written premium for direct and assumed business; or

(b) with respect to life, annuity, and disability business, the total reserve credit taken for

business ceded represents, on an annualized basis, less than 10% of the statutory reserve requirement prior to any cession.

(3) The following information is required to be disclosed in any report of a material nonrenewal, cancellation, or revision of ceded reinsurance agreements:

(a) the effective date of the nonrenewal, cancellation, or revision;

(b) the description of the transaction with an identification of the initiator of the transaction;

(c) the purpose or reason for the transaction; and

(d) if applicable, the identity of the replacement reinsurers.

(4) Insurers are required to report all material nonrenewals, cancellations, or revisions of ceded reinsurance agreements on a nonconsolidated basis unless the insurer is part of a consolidated group of insurers that uses a pooling arrangement or 100% reinsurance agreement that affects the solvency and integrity of the insurer's reserves and the insurer ceded substantially all of its direct and assumed business to the pool. An insurer is considered to have ceded substantially all of its direct and assumed business to a pool if the insurer has less than \$1 million total direct plus assumed written premiums during a calendar year that are not subject to a pooling arrangement and the net income of the business not subject to the pooling arrangement represents less than 5% of the insurer's capital and surplus.

NEW SECTION. Section 82. Short title. [Sections 82 through 94] constitute and may be referred to as "The Risk-Based Capital For Insurers Act".

NEW SECTION. Section 83. Definitions. As used in [sections 82 through 94], the following definitions apply:

(1) "Adjusted RBC report" means an RBC report that has been adjusted by the commissioner in accordance with [section 84(5)].

(2) "Corrective order" means an order issued by the commissioner specifying corrective actions that the commissioner has determined are required.

(3) "Domestic insurer" means any insurance company domiciled in this state.

(4) "Foreign insurer" means any insurance company licensed to do business in this state under 33-2-116 but not domiciled in this state.

(5) "Life or disability insurer" means:

1 (a) any insurance company licensed under 33-2-116 and engaged in the business of entering
2 into contracts of disability insurance as described in 33-1-207 or life insurance as described in
3 33-1-208; or

4 (b) a licensed property and casualty insurer writing only disability insurance.

5 (6) "NAIC" means the national association of insurance commissioners.

6 (7) "Negative trend" means, with respect to a life or health insurer, a negative trend over a
7 period of time, as determined in accordance with the trend test calculation included in the RBC
8 instructions.

9 (8) (a) "Property and casualty insurer" means any insurance company licensed under 33-2-116
10 and engaged in the business of entering into contracts of property insurance as described in 33-1-210
11 or casualty insurance as described in 33-1-206.

12 (b) The term does not include monoline mortgage guaranty insurers, financial guaranty insurers,
13 and title insurers.

14 (9) "RBC instructions" means the RBC report including risk-based capital instructions adopted
15 by the NAIC, as the RBC instructions may be amended by the NAIC from time to time in accordance
16 with the procedures adopted by the NAIC.

17 (10) "RBC level" means an insurer's authorized control level RBC, company action level RBC,
18 mandatory control level RBC, or regulatory action level RBC, where:

19 (a) "authorized control level RBC" means the number determined under the risk-based capital
20 formula in accordance with the RBC instructions;

21 (b) "company action level RBC" means, with respect to any insurer, the product of 2 and its
22 authorized control level RBC;

23 (c) "mandatory control level RBC" means the product of 0.70 and the authorized control level
24 RBC; and

25 (d) "regulatory action level RBC" means the product of 1.5 and its authorized control level RBC.

26 (11) "RBC plan" means a comprehensive financial plan containing the elements specified in
27 [section 85(2)]. If the commissioner rejects the RBC plan and it is revised by the insurer, with or
28 without the commissioner's recommendation, the plan must be called a revised RBC plan.

29 (12) "RBC report" means the report required in [section 84].

30 (13) "Total adjusted capital" means the sum of:

- 1 (a) an insurer's statutory capital and surplus; and
- 2 (b) other items, if any, as the RBC instructions may provide.

3

4 **NEW SECTION. Section 84. RBC reports.** (1) Each domestic insurer shall, on or before each

5 March 1 filing date, prepare and submit to the commissioner a report of its RBC levels as of the end

6 of the previous calendar year in a form and containing information as required by the RBC instructions.

7 In addition, each domestic insurer shall file its RBC report:

- 8 (a) with the NAIC in accordance with the RBC instructions; and
- 9 (b) with the insurance commissioner in any state in which the insurer is authorized to do
- 10 business if that insurance commissioner has notified the insurer of the request in writing, in which case
- 11 the insurer shall file its RBC report not later than the later of:

- 12 (i) 15 days from the receipt of notice to file its RBC report with that state; or
- 13 (ii) the March 1 filing date.

14 (2) A life and disability insurer's RBC must be determined in accordance with the formula set

15 forth in the RBC instructions. The formula must take into account and may adjust for the covariance

16 between:

- 17 (a) the risk with respect to the insurer's assets;
- 18 (b) the risk of adverse insurance experience with respect to the insurer's liabilities and
- 19 obligations;

20 (c) the interest rate risk with respect to the insurer's business; and

21 (d) all other business risks and other relevant risks as are set forth in the RBC instructions and

22 determined in each case by applying the factors in the manner set forth in the RBC instructions.

23 (3) A property and casualty insurer's RBC must be determined in accordance with the formula

24 set forth in the RBC instructions. The formula shall take into account and may adjust for the covariance

25 between:

26 (a) asset risk;

27 (b) credit risk;

28 (c) underwriting risk; and

29 (d) all other business risks and other relevant risks that are set forth in the RBC instructions

30 and determined in each case by applying the factors in the manner set forth in the RBC instructions.

1 (4) An excess of capital over the amount produced by the risk-based capital requirements
2 contained in [sections 82 through 94] and the formulas, schedules, and instructions referenced in
3 [sections 87 through 94] is desirable in the business of insurance. Accordingly, insurers should seek
4 to maintain capital above the RBC levels required by [sections 82 through 94]. Additional capital is
5 used and useful in the insurance business and helps to secure an insurer against various risks inherent
6 in or affecting the business of insurance and not accounted for or only partially measured by the
7 risk-based capital requirements contained in [sections 82 through 94].

8 (5) If a domestic insurer files an RBC report that in the judgment of the commissioner is
9 inaccurate, the commissioner shall adjust the RBC report to correct the inaccuracy and shall notify the
10 insurer of the adjustment. The notice must contain a statement of the reason for the adjustment. An
11 RBC report so adjusted is referred to as an adjusted RBC report.

12
13 **NEW SECTION. Section 85. Company action level event.** (1) "Company action level event"
14 means any of the following events:

15 (a) the filing of an RBC report by an insurer which indicates that:

16 (i) the insurer's total adjusted capital is greater than or equal to its regulatory action level RBC
17 but less than its company action level RBC; or

18 (ii) for a life or disability insurer, the insurer has total adjusted capital that is greater than or
19 equal to its company action level RBC but less than the product of its authorized control level RBC and
20 2.5 and that has a negative trend;

21 (b) the notification by the commissioner to the insurer of an adjusted RBC report that indicates
22 an event in subsection (1)(a) if the insurer does not challenge the adjusted RBC report under [section
23 89] or if the commissioner has rejected the insurer's challenge.

24 (2) In the event of a company action level event, the insurer shall prepare and submit to the
25 commissioner an RBC plan that must:

26 (a) identify the conditions that contribute to the company action level event;

27 (b) contain proposals of corrective actions that the insurer intends to take and that would be
28 expected to result in the elimination of the company action level event;

29 (c) provide projections of the insurer's financial results in the current year and at least the next
30 4 years, both in the absence of proposed corrective actions and giving effect to the proposed corrective

1 actions, including projections of statutory operating income, net income, capital, and surplus. The
2 projections for both new and renewal business may include separate projections for each major line of
3 business and separately identify each significant income, expense, and benefit component.

4 (d) identify the key assumptions impacting the insurer's projections and the sensitivity of the
5 projections to the assumptions; and

6 (e) identify the quality of and problems associated with the insurer's business, including but
7 not limited to its assets, anticipated business growth and associated surplus strain, extraordinary
8 exposure to risk, mix of business, and use of reinsurance, if any, in each case.

9 (3) The RBC plan must be submitted:

10 (a) within 45 days of the company action level event; or

11 (b) if the insurer challenges an adjusted RBC report pursuant to [section 89], within 45 days
12 after notification to the insurer that the commissioner has, after a hearing, rejected the insurer's
13 challenge.

14 (4) Within 60 days after the submission by an insurer of an RBC plan to the commissioner, the
15 commissioner shall notify the insurer as to whether the RBC plan may be implemented or is
16 unsatisfactory in the judgment of the commissioner. If the commissioner determines that the RBC plan
17 is unsatisfactory, the notification to the insurer must set forth the reasons for the determination and
18 may set forth proposed revisions that will render the RBC plan satisfactory in the judgment of the
19 commissioner. Upon notification from the commissioner, the insurer shall prepare a revised RBC plan,
20 which may incorporate by reference any revisions proposed by the commissioner, and shall submit the
21 revised RBC plan to the commissioner:

22 (a) within 45 days after the notification from the commissioner; or

23 (b) if the insurer challenges the notification from the commissioner under [section 89], within
24 45 days after a notification to the insurer that the commissioner has, after a hearing, rejected the
25 insurer's challenge.

26 (5) In the event of a notification by the commissioner to an insurer that the insurer's RBC plan
27 or revised RBC plan is unsatisfactory, the commissioner may at the commissioner's discretion, subject
28 to the insurer's right to a hearing under [section 89], specify in the notification that the notification
29 constitutes a regulatory action level event.

30 (6) Each domestic insurer that files an RBC plan or revised RBC plan with the commissioner

1 shall file a copy of the RBC plan or revised RBC plan with the insurance commissioner in any state in
2 which the insurer is authorized to do business if:

3 (a) the state has an RBC provision substantially similar to [section 90(1)]; and

4 (b) the insurance commissioner of that state has notified the insurer in writing of its request
5 for the filing, in which case the insurer shall file a copy of the RBC plan or revised RBC plan in that state
6 by the later of:

7 (i) 15 days after the receipt of notice to file a copy of its RBC plan or revised RBC plan with
8 that state; or

9 (ii) the date on which the RBC plan or revised RBC plan is filed under [section 85(3) and (4)].

10
11 **NEW SECTION. Section 86. Regulatory action level event.** (1) "Regulatory action level event"
12 means, with respect to any insurer, any of the following events:

13 (a) the filing of an RBC report by the insurer that indicates that the insurer's total adjusted
14 capital is greater than or equal to its authorized control level RBC but less than its regulatory action level
15 RBC;

16 (b) the notification by the commissioner to an insurer of an adjusted RBC report that indicates
17 the event in subsection (1)(a) if the insurer does not challenge the adjusted RBC report under [section
18 89] or the commissioner rejects the insurer's challenge;

19 (c) the failure of the insurer to file an RBC report by the filing date, unless the insurer has
20 provided an explanation for the failure that is satisfactory to the commissioner and has cured the failure
21 within 10 days after the filing date;

22 (d) the failure of the insurer to submit an RBC plan to the commissioner within the time period
23 set forth in [section 85(3)];

24 (e) notification by the commissioner to the insurer that:

25 (i) the RBC plan or revised RBC plan submitted by the insurer is unsatisfactory in the judgment
26 of the commissioner; and

27 (ii) the notification constitutes a regulatory action level event with respect to the insurer if the
28 insurer has not challenged the determination under [section 89];

29 (f) if, pursuant to [section 89], the insurer challenges a determination by the commissioner, the
30 notification by the commissioner to the insurer that the commissioner has, after a hearing, rejected the

1 challenge;

2 (g) notification by the commissioner to the insurer that the insurer has failed to adhere to its
3 RBC plan or revised RBC plan, but only if the failure has a substantial adverse effect on the ability of
4 the insurer to eliminate the company action level event in accordance with its RBC plan or revised RBC
5 plan and the commissioner has so stated in the notification and if the insurer has not challenged the
6 determination under [section 89] or the commissioner has not rejected the insurer's challenge.

7 (2) In the event of a regulatory action level event, the commissioner shall:

8 (a) require the insurer to prepare and submit an RBC plan or, if applicable, a revised RBC plan;

9 (b) perform an examination or analysis as the commissioner considers necessary of the assets,
10 liabilities, and operations of the insurer including a review of its RBC plan or revised RBC plan; and

11 (c) subsequent to the examination or analysis, issue a corrective order specifying corrective
12 actions that the commissioner determines are required.

13 (3) In determining corrective actions, the commissioner may take into account factors
14 considered relevant with respect to the insurer based upon the commissioner's examination or analysis
15 of the assets, liabilities, and operations of the insurer, including but not limited to the results of any
16 sensitivity tests undertaken pursuant to the RBC instructions. The RBC plan or revised RBC plan must
17 be submitted:

18 (a) within 45 days after the occurrence of the regulatory action level event;

19 (b) if the insurer challenges an adjusted RBC report pursuant to [section 89] and the challenge
20 is not frivolous in the judgment of the commissioner, within 45 days after the notification to the insurer
21 that the commissioner has, after a hearing, rejected the insurer's challenge; or

22 (c) if the insurer challenges a revised RBC plan pursuant to [section 89] and the challenge is
23 not frivolous in the judgment of the commissioner, within 45 days after the notification to the insurer
24 that the commissioner has, after a hearing, rejected the insurer's challenge.

25 (4) The commissioner may retain actuaries and investment experts and other consultants that
26 may be necessary in the judgment of the commissioner to review the insurer's RBC plan or revised RBC
27 plan, to examine or analyze the assets, liabilities, and operations of the insurer, and to formulate the
28 corrective order with respect to the insurer. The fees, costs, and expenses relating to consultants must
29 be borne by the affected insurer or such other party as directed by the commissioner.
30

1 **NEW SECTION. Section 87. Authorized control level event.** (1) "Authorized control level
2 event" means any of the following events:

3 (a) the filing of an RBC report by the insurer that indicates that the insurer's total adjusted
4 capital is greater than or equal to its mandatory control level RBC but less than its authorized control
5 level RBC;

6 (b) the notification by the commissioner to the insurer of an adjusted RBC report that indicates
7 the event in subsection (1)(a) if the insurer does not challenge the adjusted RBC report under [section
8 89] or the commissioner rejects the insurer's challenge;

9 (c) the failure of the insurer to respond, in a manner satisfactory to the commissioner, to a
10 corrective order if the insurer has not challenged the corrective order under [section 89]; or

11 (d) if the insurer has challenged a corrective order under [section 89] and the commissioner
12 has, after a hearing, rejected the challenge or modified the corrective order, the failure of the insurer
13 to respond, in a manner satisfactory to the commissioner, to the corrective order subsequent to
14 rejection or modification by the commissioner.

15 (2) In the event of an authorized control level event with respect to an insurer, the
16 commissioner shall:

17 (a) take the actions required under [section 86] regarding an insurer with respect to which a
18 regulatory action level event has occurred; or

19 (b) if the commissioner considers it to be in the best interests of the policyholders and creditors
20 of the insurer and of the public, take the actions necessary to cause the insurer to be placed under
21 regulatory control under Title 33, chapter 2, part 13. In the event that the commissioner places the
22 insurer under regulatory control, the authorized control level event must be considered sufficient
23 grounds for the commissioner to take action under Title 33, chapter 2, part 13, and the commissioner
24 shall have the rights, powers, and duties with respect to the insurer as are set forth in Title 33, chapter
25 2, part 13. In the event that the commissioner takes an action under this subsection pursuant to an
26 adjusted RBC report, the insurer is entitled to the protections afforded to insurers under the provisions
27 of 33-2-1321 through 33-2-1323 pertaining to summary proceedings.
28

29 **NEW SECTION. Section 88. Mandatory control level event.** (1) "Mandatory control level
30 event" means any of the following events:

1 (a) the filing of an RBC report that indicates that the insurer's total adjusted capital is less than
2 its mandatory control level RBC;

3 (b) notification by the commissioner to the insurer of an adjusted RBC report that indicates the
4 event in subsection (1)(a) if the insurer does not challenge the adjusted RBC report under [section 89]
5 or the commissioner rejects the insurer's challenge.

6 (2) In the event of a mandatory control level event:

7 (a) with respect to a life insurer, the commissioner shall take the actions that are necessary to
8 place the insurer under regulatory control under Title 33, chapter 2, part 13. In that event, the
9 mandatory control level event must be considered sufficient grounds for the commissioner to take
10 action under Title 33, chapter 2, part 13, and the commissioner shall have the rights, powers, and
11 duties with respect to the insurer as are set forth in Title 33, chapter 2, part 13. If the commissioner
12 takes an action pursuant to an adjusted RBC report, the insurer is entitled to the protections of
13 33-2-1321 through 33-2-1323 pertaining to summary proceedings. Notwithstanding any of the
14 foregoing, the commissioner may forego action for up to 90 days after the mandatory control level
15 event if the commissioner finds that there is a reasonable expectation that the mandatory control level
16 event may be eliminated within the 90-day period.

17 (b) with respect to a property and casualty insurer, the commissioner shall take the actions
18 necessary to place the insurer under regulatory control under Title 33, chapter 2, part 13, or, in the
19 case of an insurer that is not writing business and that is running-off its existing business, may allow
20 the insurer to continue its runoff under the supervision of the commissioner. In either event, the
21 mandatory control level event must be considered sufficient grounds for the commissioner to take
22 action under Title 33, chapter 2, part 13, and the commissioner shall have the rights, powers, and
23 duties with respect to the insurer as are set forth in Title 33, chapter 2, part 13. If the commissioner
24 takes an action pursuant to an adjusted RBC report, the insurer is entitled to the protections of
25 33-2-1321 through 33-2-1323 pertaining to summary proceedings. Notwithstanding any of the
26 foregoing, the commissioner may forego action for up to 90 days after the mandatory control level
27 event if the commissioner finds there is a reasonable expectation that the mandatory control level event
28 may be eliminated within the 90-day period.

29
30 **NEW SECTION. Section 89. Notification and hearing.** (1) An insurer has the right to a hearing

1 before the department upon notification by the commissioner:

2 (a) of an adjusted RBC report or unsatisfactory RBC plan or revised RBC plan that constitutes
3 a regulatory action level event with respect to the insurer;

4 (b) that the insurer has failed to adhere to its RBC plan or revised RBC plan and that the failure
5 has a substantial adverse effect on the ability of the insurer to eliminate the company action level event
6 with respect to the insurer in accordance with its RBC plan or revised RBC plan; or

7 (c) of a corrective order with respect to the insurer.

8 (2) The insurer shall notify the commissioner of its request for a hearing within 5 days after
9 the notification by the commissioner under subsection (1). Upon receipt of the insurer's request for
10 a hearing, the commissioner shall set a date for the hearing, which may not be less than 10 or more
11 than 30 days after the date of the insurer's request.

12

13 **NEW SECTION. Section 90. Confidentiality -- prohibition on announcements -- prohibition on**
14 **use in ratemaking.** (1) With respect to a domestic insurer or a foreign insurer, all RBC reports, to the
15 extent the information in the reports is not required to be set forth in a publicly available annual
16 statement schedule, and all RBC plans, including the results or report of any examination or analysis
17 of an insurer performed pursuant to [sections 82 through 94] and any corrective order issued by the
18 commissioner pursuant to the examination or analysis, that are filed with the commissioner constitute
19 information that might be damaging to the insurer if made available to its competitors and must be kept
20 confidential by the commissioner. This information may not be made public and is not subject to
21 subpoena other than by the commissioner and then only for the purpose of enforcement actions taken
22 by the commissioner pursuant to [sections 82 through 94] or any other provision of the insurance laws
23 of this state.

24 (2) It is the intent of the legislature that the comparison of an insurer's total adjusted capital
25 to any of its RBC levels is a regulatory tool that may indicate the need for possible corrective action
26 with respect to the insurer and that it is not intended as a means to rank insurers generally. Except as
27 otherwise required under the provisions of [sections 92 through 94], the making, publishing,
28 disseminating, circulating, or placing before the public or causing, directly or indirectly to be made,
29 published, disseminated, circulated, or placed before the public, in a newspaper, magazine, or other
30 publication, in the form of a notice, circular, pamphlet, letter, or poster, over any radio or television

1 station, or in any other way, an advertisement, announcement, or statement containing an assertion,
2 representation, or statement with regard to the RBC levels of any insurer or of any component derived
3 in the calculation that is by any insurer, producer, or other person engaged in any manner in the
4 insurance business would be misleading and is prohibited. However, if any materially false statement
5 with respect to the comparison regarding an insurer's total adjusted capital to its RBC levels or an
6 inappropriate comparison of any other amount to the insurer's RBC levels is published in any written
7 publication and the insurer is able to demonstrate to the commissioner, with substantial proof, the
8 falsity of the statement or the inappropriateness, as the case may be, the insurer may publish an
9 announcement in a written publication if the sole purpose of the announcement is to rebut the
10 materially false statement.

11 (3) It is the further intent of the legislature that the RBC instructions, RBC reports, adjusted
12 RBC reports, RBC plans, and revised RBC plans are intended solely for use by the commissioner in
13 monitoring the solvency of insurers and the need for possible corrective action with respect to insurers
14 and may not be used by the commissioner for ratemaking or considered or introduced as evidence in
15 any rate proceeding or used by the commissioner to calculate or derive any elements of an appropriate
16 premium level or rate of return for any line of insurance that an insurer or any affiliate is authorized to
17 write.

18
19 **NEW SECTION. Section 91. Supplemental provisions -- rules -- exemption.** (1) The provisions
20 of [sections 82 through 94] are supplemental to any other provisions of the laws of this state and do
21 not preclude or limit any other powers or duties of the commissioner under the law, including but not
22 limited to Title 33, chapter 2, part 13.

23 (2) The commissioner may adopt reasonable rules necessary for the implementation of [sections
24 82 through 94].

25 (3) The commissioner may exempt from the application of [sections 82 through 94] any
26 domestic property and casualty insurer that:

- 27 (a) writes direct business only in this state;
28 (b) writes direct annual premiums of \$2 million or less; and
29 (c) does not assume reinsurance in excess of 5% of direct premium written.

30

1 **NEW SECTION. Section 92. Foreign insurers.** (1) A foreign insurer shall, upon the written
2 request of the commissioner, submit to the commissioner an RBC report for the previous calendar year
3 on the later of:

4 (a) the date that an RBC report would be required to be filed by a domestic insurer under
5 [section 84]; or

6 (b) 15 days after the request is received by the foreign insurer.

7 (2) A foreign insurer shall, at the written request of the commissioner, promptly submit to the
8 commissioner a copy of any RBC plan that is filed with the insurance commissioner of any other state.

9 (3) In the event of a company action level event, regulatory action level event, or authorized
10 control level event, with respect to any foreign insurer as determined under the RBC statute applicable
11 in the state of domicile of the insurer or, if an RBC statute is not in force in that state, under the
12 provisions of [sections 82 through 94], if the insurance commissioner of the state of domicile of the
13 foreign insurer fails to require the foreign insurer to file an RBC plan in the manner specified under that
14 state's RBC statute or, if an RBC statute is not in force in that state, under [section 85], the
15 commissioner may require the foreign insurer to file an RBC plan with the commissioner. In that event,
16 the failure of the foreign insurer to file an RBC plan with the commissioner is grounds to order the
17 insurer to cease and desist from writing new insurance business in this state.

18 (4) In the event of a mandatory control level event with respect to any foreign insurer, if a
19 domiciliary receiver has not been appointed with respect to the foreign insurer under the rehabilitation
20 and liquidation statute applicable in the state of domicile of the foreign insurer, the commissioner may
21 make application to a district court of this state permitted under 33-2-1380 with respect to the
22 liquidation of property of foreign insurers found in this state, and the occurrence of the mandatory
23 control level event must be considered adequate grounds for the application.

24
25 **NEW SECTION. Section 93. Applicability for 1995.** (1) For RBC reports required to be filed
26 by property and casualty insurers with respect to 1995, the following requirements apply in lieu of the
27 provisions of [sections 85 through 88]:

28 (a) In the event of a company action level event with respect to a domestic insurer, the
29 commissioner will not take regulatory action under [sections 82 through 94].

30 (b) In the event of a regulatory action level event under [section 86(1)(a), (1)(b), or (1)(c)], the

1 commissioner shall take the actions required under [section 86(2)].

2 (c) In the event of a regulatory action level event under [section 86(1)(d), (1)(e), (1)(f), or
3 (1)(g)] or an authorized control level event, the commissioner shall take the actions required under
4 [section 86(2) and (3)] with respect to the insurer.

5 (4) In the event of a mandatory control level event with respect to an insurer, the commissioner
6 shall take the actions required under [section 88].

7
8 NEW SECTION. Section 94. Notices. All notices by the commissioner to an insurer that may
9 result in regulatory action are effective on dispatch if transmitted by certified mail or, in the case of any
10 other transmission, are effective on the insurer's receipt of the notice.

11
12 SECTION 95. SECTION 33-22-1811, MCA, IS AMENDED TO READ:

13 "**33-22-1811. Availability of coverage -- required plans.** (1) (a) As a condition of transacting
14 business in this state with small employers, each small employer carrier shall offer to small employers
15 at least two health benefit plans. One plan must be a basic health benefit plan, and one plan must be
16 a standard health benefit plan.

17 (b) (i) A small employer carrier shall issue a basic health benefit plan or a standard health
18 benefit plan to any eligible small employer that applies for either plan and agrees to make the required
19 premium payments and to satisfy the other reasonable provisions of the health benefit plan not
20 inconsistent with this part.

21 (ii) In the case of a small employer carrier that establishes more than one class of business
22 pursuant to 33-22-1808, the small employer carrier shall maintain and offer to eligible small employers
23 at least one basic health benefit plan and at least one standard health benefit plan in each established
24 class of business. A small employer carrier may apply reasonable criteria in determining whether to
25 accept a small employer into a class of business, provided that:

26 (A) the criteria are not intended to discourage or prevent acceptance of small employers
27 applying for a basic or standard health benefit plan;

28 (B) the criteria are not related to the health status or claims experience of the small employers'
29 employees;

30 (C) the criteria are applied consistently to all small employers that apply for coverage in that

1 class of business; and

2 (D) the small employer carrier provides for the acceptance of all eligible small employers into

3 one or more classes of business.

4 (iii) The provisions of subsection (1)(b)(ii) may not be applied to a class of business into which

5 the small employer carrier is no longer enrolling new small businesses.

6 (c) The provisions of this section are effective 180 days after the commissioner's approval of

7 the basic health benefit plan and the standard health benefit plan developed pursuant to 33-22-1812,

8 provided that if the program created pursuant to 33-22-1818 is not yet operative on that date, the

9 provisions of this section are effective on the date that the program begins operation.

10 (2) (a) A small employer carrier shall, pursuant to 33-1-501, file the basic health benefit plans

11 and the standard health benefit plans to be used by the small employer carrier.

12 (b) The commissioner may at any time, after providing notice and an opportunity for a hearing

13 to the small employer carrier, disapprove the continued use by a small employer carrier of a basic or

14 standard health benefit plan on the grounds that the plan does not meet the requirements of this part.

15 (3) Health benefit plans covering small employers must comply with the following provisions:

16 (a) A health benefit plan may not, because of a preexisting condition, deny, exclude, or limit

17 benefits for a covered individual for losses incurred more than 12 months following the effective date

18 of the individual's coverage. A health benefit plan may not define a preexisting condition more

19 restrictively than 33-22-110, except that the condition may be excluded for a maximum of 12 months.

20 (b) A health benefit plan must waive any time period applicable to a preexisting condition

21 exclusion or limitation period with respect to particular services for the period of time an individual was

22 previously covered by qualifying previous coverage that provided benefits with respect to those services

23 if the qualifying previous coverage was continuous to a date not less more than 30 days prior to the

24 submission of an application for new coverage. This subsection (3)(b) does not preclude application of

25 any waiting period applicable to all new enrollees under the health benefit plan.

26 (c) A health benefit plan may exclude coverage for late enrollees for 18 months or for an

27 18-month preexisting condition exclusion, provided that if both a period of exclusion from coverage and

28 a preexisting condition exclusion are applicable to a late enrollee, the combined period may not exceed

29 18 months from the date the individual enrolls for coverage under the health benefit plan.

30 (d) (i) Requirements used by a small employer carrier in determining whether to provide

1 coverage to a small employer, including requirements for minimum participation of eligible employees
2 and minimum employer contributions, must be applied uniformly among all small employers that have
3 the same number of eligible employees and that apply for coverage or receive coverage from the small
4 employer carrier.

5 (ii) A small employer carrier may vary the application of minimum participation requirements
6 and minimum employer contribution requirements only by the size of the small employer group.

7 (e) (i) If a small employer carrier offers coverage to a small employer, the small employer carrier
8 shall offer coverage to all of the eligible employees of a small employer and their dependents. A small
9 employer carrier may not offer coverage only to certain individuals in a small employer group or only
10 to part of the group, except in the case of late enrollees as provided in subsection (3)(c).

11 (ii) A small employer carrier may not modify a basic or standard health benefit plan with respect
12 to a small employer or any eligible employee or dependent, through riders, endorsements, or otherwise,
13 to restrict or exclude coverage for certain diseases or medical conditions otherwise covered by the
14 health benefit plan.

15 (4) (a) A small employer carrier may not be required to offer coverage or accept applications
16 pursuant to subsection (1) in the case of the following:

17 (i) to a small employer when the small employer is not physically located in the carrier's
18 established geographic service area;

19 (ii) to an employee when the employee does not work or reside within the carrier's established
20 geographic service area; or

21 (iii) within an area where the small employer carrier reasonably anticipates and demonstrates
22 to the satisfaction of the commissioner that it will not have the capacity within its established
23 geographic service area to deliver service adequately to the members of a group because of its
24 obligations to existing group policyholders and enrollees.

25 (b) A small employer carrier may not be required to provide coverage to small employers
26 pursuant to subsection (1) for any period of time for which the commissioner determines that requiring
27 the acceptance of small employers in accordance with the provisions of subsection (1) would place the
28 small employer carrier in a financially impaired condition."

29
30 **SECTION 96. SECTION 33-1-413, MCA, IS AMENDED TO READ:**

1 **"33-1-413. Examination expense -- lien.** (1) Upon presentation of a detailed account of ~~such~~
2 charges and expenses by the commissioner or pursuant to ~~his~~ the commissioner's written authorization,
3 each person ~~se~~ examined, other than ~~as to~~ examinations pursuant to 33-1-402, shall pay the actual
4 travel expenses, a reasonable living expense allowance, and a per diem as compensation of examiners
5 as necessarily incurred on account of the examination, all at reasonable rates ~~customary therefor and~~
6 as established or adopted by the commissioner. ~~Such an~~ An account may be ~~se~~ presented periodically
7 during the course of the examination or at the termination of the examination as the commissioner
8 ~~deems~~ considers proper. ~~No~~ A person ~~shall~~ may not pay and ~~no~~ an examiner ~~shall~~ may not accept any
9 additional emolument on account of ~~any such~~ an examination.

10 (2) The commissioner shall pay to the state treasurer to the credit of the ~~general~~ state special
11 revenue fund all ~~moneys~~ money received pursuant to subsection (1) ~~above~~.

12 (3) If ~~any such~~ a person fails to pay the charges and expenses, as referred to in subsection (1)
13 ~~above, they shall~~ the charges and expenses must be paid out of the funds of the commissioner in the
14 same manner as other disbursements of ~~such the~~ funds. The amount ~~se paid shall be~~ is a first lien upon
15 all of the assets and property in this state of ~~such the~~ person and may be recovered by suit by the
16 attorney general on behalf of the state of Montana and restored to the appropriate fund."

17
18 NEW SECTION. Section 97. Repealer. Sections 33-30-312 and 33-30-313, MCA, are
19 repealed.

20
21 NEW SECTION. Section 98. Codification instruction. (1) [Section 75] is intended to be
22 codified as an integral part of Title 33, chapter 15, and the provisions of Title 33, chapter 15, apply
23 to [section 75].

24 (2) [Section 76] is intended to be codified as an integral part of Title 33, chapter 2, part 5, and
25 the provisions of Title 33, chapter 2, part 5, apply to [section 76].

26 (3) [Section 77] is intended to be codified as an integral part of Title 33, chapter 15, part 4,
27 and the provisions of Title 33, chapter 15, part 4, apply to [section 77].

28 (4) [Sections 78 through 81] are intended to be codified as an integral part of Title 33, chapter
29 3, and the provisions of Title 33, chapter 3, apply to [sections 78 through 81].

30 (5) [Sections 82 through 94] are intended to be codified as an integral part of Title 33, chapter

1 2, and the provisions of Title 33, chapter 2, apply to [sections 82 through 94].

2
3 NEW SECTION. Section 99. Severability. If a part of [this act] is invalid, all valid parts that
4 are severable from the invalid part remain in effect. If a part of [this act] is invalid in one or more of
5 its applications, the part remains in effect in all valid applications that are severable from the invalid
6 applications.

7
8 NEW SECTION. SECTION 100. EFFECTIVE DATES. (1) [SECTION 31 AND THIS SECTION]
9 ARE EFFECTIVE ON PASSAGE AND APPROVAL.

10 (2) ~~[SECTIONS 1 THROUGH 30 AND 32 THROUGH 98] ARE EXCEPT AS PROVIDED IN~~
11 SUBSECTION (1), [THIS ACT] IS EFFECTIVE OCTOBER 1, 1995.

12 -END-